LOUISIANA DEPARTMENT OF HEALTH
Medicaid

ELEVATED LEVEL OF CARE (ELOC) TRANSPORTATION PRIOR APPROVAL FORM

SECTION I – GENERAL INFORMATION

Patient's Last Name: _____ **Patient's First Name:** _____ **MI:** _____

Gender: ☐ Male ☐ Female **Date of Birth (MM/DD/YYYY):** ____/____/_____ **Medicaid ID#:** _____

Transport Date (if form will be used for a single transport) : _____/_____/_____ **Round Trip:** ☐ Yes ☐ No

Date Range (if applicable) **Start date:** ____/____/_____ **End date:** ____/____/_____

☐ 180 days from start date

Transport from: ☐ Home, or _____

Transport To: _____

SECTION II – SIGNATURE OF PHYSICIAN OR OTHER AUTHORIZED HEALTHCARE PROFESSIONAL

Certifying Physician/Practitioner Information:

Facility: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Telephone number *(and extension if applicable):* _____ Extension: _____

I certify that the information contained in this document represents an accurate assessment of the patient's medical condition on the date(s) of service.

X _____ _____

Signature of Physician or Authorized Healthcare Professional **Date Signed**

_____ _____

Printed Name of Physician or Authorized Healthcare Professional **NPI or License Number**

☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner
☐ Registered Nurse (RN) ☐ Clinical Nurse Specialist (CNS)

Please complete page 2

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Patient Name:	Date:
DOB:_____/_____/_____	Medicaid ID#:

SECTION III – MEDICAL NECESSITY QUESTIONNAIRE

Description of ELOC Services

The healthcare provider must document the specific elevated level of care service(s) requested for the beneficiary in the space provided. The transportation broker will communicate this information to the assigned NEMT provider to ensure appropriate service delivery.

Diagnosis: ICD Code and Description

Diagnosis ICD Code:	Diagnosis ICD Description:
Diagnosis ICD Code:	Diagnosis ICD Description:
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Additional Information