Physician Referral Form

The Department of Vermont Health Access (DVHA) helps people on Medicaid or Dr. Dynasaur with transportation to get to their medical appointments or pick up prescriptions. Please complete and sign this form in order for us to determine if this trip should be covered by Medicaid. Please mail or fax the form to:

Medicaid Transportation
DVHA
312 Hurricane Lane, Suite 201
Williston, VT 05495

Fax: (802) 879-5919

Client Name: _____

Unique ID: _____ DOB: _____

Appointment Date and Time: _____

Name of Primary Physician: _____

Name of Physician to whom
Client is Being Referred: _____

Address: _____

_____

Phone: _____

Is overnight lodging necessary? Yes ☐ No ☐

Medically, how many people should accompany the patient (other than the driver)? _____ Please explain on next page.

Transportation Broker:
Address:
Phone:

DVHA Decision: Approved ☐ Denied ☐

Authorized by: _____ Date: _____

rev 7/14

Please check “yes” or “no” to all of the following questions:

Yes	No	
☐	☐	**Is this service obtainable in Vermont?**
☐	☐	**Have efforts been made to find a closer provider?**
☐	☐	**Does the requested physician possess special expertise?**
☐	☐	**Is it medically necessary for this physician to treat this patient?**
☐	☐	**Does the patient have a history with this specific provider?**
☐	☐	**Can another physician take over this case if a history does exist?**
☐	☐	**If this is an out-of-state/out-of-network request, is a Clinical prior authorization in place?**

Please describe the specific service or medical care that this member needs a ride to:

_____

_____

Is there a medical reason for someone to accompany the member on this trip?_____

_____

If necessary, please add any further information: _____

_____

_____

_____ _____

Print name of Doctor or Doctor’s Staff providing information Phone

_____ _____

Signature of Doctor or Doctor’s Staff providing information Date