Level of Need (LON) Assessment Form Instructions

MTM has two LON assessment forms: the Standard LON Form and the Ambulance/Stretcher LON Form. ***LON Forms must be completed by a medical professional who is currently treating the member.***

The **Standard LON Form** is for both cab (ambulatory) and wheelchair (para lift) modes.

- This LON must be filled out for cab/ambulatory services if a member is within 3/4 mile of bus stop but needs a higher mode of transportation due to medical restrictions or needs. Exclusions include:
    - A member who is more than six months pregnant
    - Short notice or urgent trips
    - A member who is traveling to dialysis, chemotherapy, or radiation
    - A member who is further than 3/4 mile from a bus stop for the pick-up and drop-off addresses
    - A member who already has a LON on file for a higher mode of transportation

The **Ambulance/Stretcher LON Form** applies when a member needs a higher mode of transportation, including stretcher, Basic Life Support (BLS), or Advanced Life Support (ALS). This LON form must also be filled out if a member uses a wheelchair or mobility aid that requires the use of a para lift vehicle.

Level of Need Assessment Form

Ambulance/Stretcher

Dear Medical Professional:

Facility Fax:

Our office has received a request for transportation; please fill out this Level of Need Assessment form completely and provide any supporting information as needed. This form will be used to determine the patient's most appropriate mode of transportation based on his or her functional abilities and limitations.

Patient Info	First Name:	Last Name:	Date of Birth:	Gender: ☐ M ☐ F
	Medical ID #:		Room #:	
	Address:	City:	State:	Zip:
Diagnosis Info	Diagnosis:		Diagnosis is: ☐ Permanent ☐ Temporary Through (date): _____	
	Does the patient have any of the following impairments? ☐ Muscular/Motor ☐ Respiratory ☐ Cardiac Function ☐ Cognitive/Psychological ☐ Other If yes, please explain:			
Transport Needs	Does patient use any of the following assistive devices? ☐ Crutches ☐ Walker ☐ Cane ☐ Electric Wheelchair ☐ Manual Wheelchair ☐ Scooter			
	Is the patient able to sit in a wheelchair? ☐ Yes ☐ No If no, please specify reason(s):			
	Does patient require monitoring by a certified Emergency Medical Technician (EMT) or paramedic during transport?	☐ Yes	☐ No	
	Does patient require use of oxygen during transport?	☐ Yes	☐ No	
	Does patient need to be lifted or carried up/down stairs in order to exit the home or provider's building?	☐ Yes	☐ No	
	Is patient able to transfer into vehicle without assistance?	☐ Yes	☐ No	
	Does patient require life-sustaining equipment during transport? ☐ No ☐ Yes If yes, please specify:			
	Does patient need to be transported in a reclining position? ☐ No ☐ Yes, for medical reasons ☐ Yes, due to a psychiatric condition If yes, please explain:			
	Does patient require a personal attendant? ☐ No ☐ Yes, for medical reasons ☐ Yes, passenger is developmentally disabled ☐ Yes, passenger is cognitively disabled			

CERTIFICATION STATEMENT: I (or the entity) understand(s) that orders for Medicaid or Medicare funded travel may result from the completion of this form. I (or the entity) certify (ies) that the statements made hereon are true, accurate and complete to the best of my knowledge; no material fact has been omitted from this form. This Certification is subject to all applicable federal, state and local laws, regulations, rules, policies and procedures.

Medical Professional Info	Printed Name:		NPI #:
	Address:		Phone #:
	Signature:		Date:
Form completed by:		Title:	Phone #:

Questions? Please call the Ambulance Utilization Management Department toll free at 1-888-561-8747.

Please fax this completed form to: 1-866-453-0247.

ATTN: Ambulance/Stretcher Authorization Specialist