Senior MedExpress Transportation Program

Healthcare Provider Certification Form

Senior MedExpress is a non-emergency transportation assistance program funded by the Department of Aging and Community Living (DACL) and administered by Yellow Cab Company for eligible DC seniors 60 years and older who have a certified medical condition requiring essential life-sustaining appointments, such as chemotherapy or dialysis treatment.

Your patient may qualify for complimentary round-trip transportation to and from your practice for essential non-emergency medical appointments. Please complete this certification form verifying your patient's medical necessity for Senior MedExpress transportation services.

TO BE FILLED BY THE PATIENT:

SECTION 1: Patient Information and Authorization of Release of Information

Name: _____ DOB: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email: _____

I,_____, hereby authorize and consent to the release of requested information by my physician or his/her designee for confirmation of my medical condition and diagnosis that require essential medical transportation to appointment(s) with my physicians, medical facilities and/or medical service agencies for which I request essential medical transportation by the Senior MedExpress Program. The purpose of this Release is solely for obtaining confirmation as I understand the Department of Aging and Community Living (DACL) must verify validity of my medical diagnosis and condition with my attending physicians' offices and any other medical facilities to and from which I request transportation services. I also understand that this Release is voluntary and that I must recertify annually.

I authorize DACL to contact my doctor to verify my medical condition for transportation purposes only. Any medical information provided to DACL concerning my diagnosis, symptoms, treatments, medical and/or doctors' visits or any other details regarding my healthcare, is subject to protection from unauthorized disclosure by federal and District law and will not be disclosed or used for any purpose other than determining my eligibility for the Senior MedExpress Program. I therefore acknowledge my full understanding of this authorization and release of information by signing below:

Signature: _____ Date: _____

Patient: _____ DOB: _____

TO BE FILLED BY THE HEALTHCARE PROVIDER (PHYSICIAN OR AUTHORIZED MEDICAL PERSONNEL):

SECTION 2: HealthCare Provider Information

Physician Name: _____ Address: _____

Practice Phone#: _____ Email: _____

List your client's diagnosis and describe the medical condition of this client that requires him/her to need essential medical appointments:

Underlying Medical Diagnosis	Medical Condition

SECTION 3: HealthCare Provider Certification

By signing this form, you are certifying that:

1. This patient requires life-sustaining essential medical appointments AND
2. You understand that information provided is subject to investigation and verification. Misrepresentation or falsification of essential information which may lead to sanctions and/or penalties under applicable Federal and/or State law. This form is valid for a period of one year from the date of signing.

Check Signee Type: □ Physician □ Physician Assistant □ Nurse (RN or LPN) □ Other _____

Signature: _____ Printed Name: _____ Date Signed: _____

Phone Number of Signee: _____ Professional License Number: _____

ALL APPLICANTS MUST SUBMIT THIS CERTIFICATION WITH THEIR COMPLETE APPLICATION TO DACL. AN APPLICATION IS NOT COMPLETE WITHOUT THIS FULLY COMPLETED AND SIGNED FORM.