HEALTH CARE PROVIDERS STATEMENT OF MEDICAL NECESSITY

This statement must be completed and signed by a health care provider employed by the facility where the patient is locally being treated and has knowledge of the medical necessity for services and the patient's medical/mental health.

Patient: _____ **DOB:** _____

Appointment Location: _____

PLEASE COMPLETE ALL THE REQUESTED INFORMATION, IF APPLICABLE (Check appropriate boxes):

☐ This patient cannot get this type of necessary medical care in the local service area and _____ is the **nearest available** medical facility to provide the medical service.

☐ This patient requires continued care medical services.

☐ This patient must have an adult attendant/family member because patient is not able to travel independently or make critical medical decisions on his/her own due to a severe physical or mental condition.

☐ This patient's written treatment plan requires the involvement of the following person/people: _____

TRANSPORTATION:

☐ This patient is unable to travel the day of his/her appointment, so must have overnight lodging because of the following medical reason: _____
_____
_____

☐ This patient is unable to use Public Transit (bus or van) due to severe medical or emotional condition.

☐ This patient is unable to drive his/her vehicle to medical appointments due to: _____
_____
_____

Health Care Provider's signature: _____ Date: _____
Name of Hospital or Clinic: _____ Phone Number: _____

Beltrami County Health and Human Services will monitor medication treatment services. Please fax completed and signed statement to MA Transportation @218-333-4131 c/o: Beltrami County Human Services. If you have questions, please call at 218-333-8023.