



Level of Need Assessment Form (LON)

Facility Fax#:

Dear Medical Professional,

Our office has received a request for non-emergency medical transportation for one of your patients. This form will be used to determine the patient's most appropriate mode of transportation based on their functional abilities and limitations, including whether your patient is able to use public transportation. Your input in completing this form is critical to ensure patients receive the correct mode of transportation. Please fill out this Level of Need Assessment (LON) form legibly and completely, providing supporting information as needed and return it to MTM as soon as possible. If LON is not received before temporary certification expires member's mode will revert to lowest mode of transportation.

Patient Information	First Name:		Last Name:		Date of Birth:	
	Address:				Medicaid ID#:	
	City:		State:	ZIP:	Phone#:	
Physical Abilities and Equipment	Can the patient ambulate independently up to ½ mile? <input type="checkbox"/> No <input type="checkbox"/> Yes					
	Does the patient use any of the following assistive devices? <input type="checkbox"/> Walker <input type="checkbox"/> Crutches <input type="checkbox"/> Cane <input type="checkbox"/> Portable Oxygen <input type="checkbox"/> Service Animal <input type="checkbox"/> Manual Wheelchair <input type="checkbox"/> Medical Leg Brace <input type="checkbox"/> Electric Wheelchair [weight:] <input type="checkbox"/> Bariatric Wheelchair [weight:] <input type="checkbox"/> None <input type="checkbox"/> Other (description):					
	Does the patient require assistance of trained personnel for safety to effectively use the assistive devices? <input type="checkbox"/> No <input type="checkbox"/> Yes					
	Does the patient require an attendant or escort for travel/assistive service? <input type="checkbox"/> No <input type="checkbox"/> Yes					
	Can the patient self-transfer from a wheelchair? <input type="checkbox"/> No <input type="checkbox"/> Yes			Can the patient remove themselves from unsafe situations? <input type="checkbox"/> No <input type="checkbox"/> Yes		
	Do environmental factors like heat or cold affect the patient's mobility to where they would not be able to use a particular mode of transportation during certain seasons? <input type="checkbox"/> No <input type="checkbox"/> Yes (please explain):					
Cognitive/Sensory Abilities	Does the patient have limitations with any of the following that would affect their ability to use a particular mode of transportation? Vision: <input type="checkbox"/> No <input type="checkbox"/> Yes Hearing: <input type="checkbox"/> No <input type="checkbox"/> Yes Alertness: <input type="checkbox"/> No <input type="checkbox"/> Yes Confusion: <input type="checkbox"/> No <input type="checkbox"/> Yes Memory Issues: <input type="checkbox"/> No <input type="checkbox"/> Yes					
Mental/Behavioral Health	Does the patient have any mental/behavioral health limitations that would affect their ability to use a particular mode of transportation? <input type="checkbox"/> No <input type="checkbox"/> Yes					
Pregnancy	Is the patient pregnant and experiencing complications that would classify their pregnancy as high risk? <input type="checkbox"/> No <input type="checkbox"/> Yes			What is the patient's expected due date?		
Transportation Certification Timeframe	Transportation limitation is: <input type="checkbox"/> Temporary Through (date): <input type="checkbox"/> Permanent (<i>*Only select permanent if the patient's condition <u>will not</u> improve.</i>)					
Additional Comments:						
Medical Professional Information						
Printed Name and Credentials:				Phone#:		
Signature:			Date:		Facility or Individual NPI # (if applicable):	

Questions? Please contact MTM at 1-888-561-8747
Please fax completed forms to: 1-877-406-0658, ATTN: Level of Need