LogistiCare

MO HealthNet Ancillary Services Form

Facility Services Phone: 866-269-5942

Fax to 1-866-269-8875

Service Requested:_____Lodging _____Gas Reimbursement_____Meal Reimbursement_____Transportation

Participant Name:_____MO HealthNet #: ___
Date of Birth:_____Phone number(s): _____
Parent/Guardian Name: _____
Home Address: _____
City:_____State:_____Zip Code: _____

Appointment Date(s) and Time(s): _____
Facility and Clinician Name: _____
Address: _____
City:_____ State:_____ Zip Code: _____
Phone Number:_____Fax Number: _____

Lodging Check In Date**:** _____ Check Out Date**:** _____

*Provided for participant and one parent/guardian if participant is a child**.**

Meals Reimbursement Dates**:** _____

*Maximum reimbursement of 2 meals each per day for child (outpatient) and one guardian.
Facility staff or parent/guardian may fax receipts with Participant name and MO HealthNet ID to 866-269-8875.

Transportation Services

*Gas Reimbursement is required if there is access to operable vehicle (or access to vehicle of friend, neighbor or family member), if physically able to drive the vehicle (or friend, neighbor, family member is), and if car is routinely used for non-medical trips.

Does Participant/Parent/Guardian have access to a vehicle for transport to facility? ☐ Yes ☐ No

Gas Reimbursement Driver:_____Social Security #: _____
Mailing Address: _____
City:_____State:_____Zip Code: _____

Is LogistiCare provider transportation needed? ☐ Yes ☐ No If Yes, please complete the section below.

☐ Ambulatory ☐ Wheelchair-Manual/ Transfer ☐ Wheelchair-Electric/Lift Required Weight:_____☐ Oversized chair?

Appointment or Check-In Date: _____ Appointment or Check-In Time: _____

Transport to: ☐ Healthcare Facility ☐ Lodging Facility ☐ No transport required

Return Home Date: _____ Pick Up Time: _____

Pick Up from: ☐ Healthcare Facility ☐ Lodging Facility ☐ No return transport required

I,_____acknowledge that I realize that NEMT services should only be provided to treatments which MO HealthNet pays for and hereby declare, under potential penalty of MO HealthNet fraud, that to the best of my knowledge and belief the above-entered information is accurate.

Signature: _____ Date Signed: _____

Phone:_____Fax:_____Email: _____

For LogistiCare Use: Trip Numbers and Dates

Lodging:_____GR:_____ Transportation: _____
Reviewed By: _____ Date: _____ ☐ Approved ☐ Denied