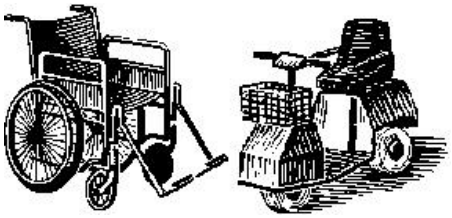

Ohio Department of Medicaid

CERTIFICATION OF NECESSITY FOR TRANSPORTATION BY WHEELCHAIR VAN

Individual Information

1. Name *(Enter the full name of the individual transported.)*	2. Ohio Medicaid Billing Number — *12 Digits*
3. Address *(Enter the individual's home address. This information may be used to confirm the identity of the individual.)*	

Transportation Provider Information

4. Provider Name *(Enter the business name of the transportation provider.)*	
FENIX MEDICAL TRANSPORTATION	
5. Ohio Medicaid Provider Number — *7 Digits*	6. National Provider Identifier (NPI), If Applicable — *10 Digits*
0024990	1386350932

Certification

7. Criteria *By signing this document, the practitioner certifies that two statements are true:* a. This individual must be accompanied by a mobility-related assistive device from the point of pick-up to the point of drop-off. b. Transport of this individual by standard passenger vehicle or common carrier is precluded or contraindicated.	8. Period Beginning Date *(Enter the first date of the certification period.)* 9. Length *(Mark <u>one</u> box to indicate the length of time for which the individual is certified for transport. For certification on a temporary basis, specify the number of calendar days, up to 90. If no time period is indicated, then the certification is valid for the Period Beginning Date only.)* ☐ Not more than day(s) ☐ One year

Additional Information Relevant to Certification

10. Comments or Explanations, If Necessary or Appropriate

Certifying Practitioner Information

11. Name of Practitioner *(Enter the full name of the certifying practitioner.)*	
12. Ohio Medicaid Provider Number, If Applicable — *7 Digits*	13. National Provider Identifier (NPI) — *10 Digits*

Signature Information

14. Date of Signature	15. Name of Person Signing
16. Signature and Professional Designation *(Persons who, with proper authority or approval, sign on behalf of the certifying practitioner must include the practitioner's name as well as their own signature and designation or job title.)*	

False certification constitutes Medicaid fraud.

This form confirms the certification of one individual for transport by one service provider; certification is not transferrable between individuals or service providers. A photocopy, an electronic copy, or a facsimile transmittal of the completed, signed, and dated certification form is as valid as the original for documentation purposes. Completion of this form is required in accordance with Chapter 5160-15 of the Ohio Administrative Code.