**Non-Emergency Medical Transportation (NEMT) for Health Home Services REQUEST FORM**

# Date:

**TO NEMT Broker: FAX #:**

**NEMT Broker Look-up:** <http://www.hca.wa.gov/medicaid/transportation/pages/phone.aspx>

# FROM (Care Coordination Organization):

**Name of Care Coordinator: Phone #**

**Health Home Lead Agency: (Check one)**

\_\_\_\_AAADSW

\_\_\_\_Amerigroup

\_\_\_\_Community Choice – Action Health Partners

\_\_\_\_Community Health Plan of WA

\_\_\_\_Coordinated Care

\_\_\_\_Full Life Care

\_\_\_\_Molina

\_\_\_\_Northwest Regional Council

\_\_\_\_Olympic AAA

\_\_\_\_Pierce County Human Services (AAA)  
\_\_\_\_Pierce County ACH

\_\_\_\_SE WA AAA

\_\_\_\_United Health Care

**Section I** - Client Information

**Last Name** **First Name**

**ProviderOne ID Number** **DOB:**

**Transportation Date** (mm/dd/yyyy) and \***Appointment Time**:

**Pick-up Address** (exact address/entrance):

**Drop-off Address** (exact address/entrance):

**ROUND TRIP (Circle one):** YES / NO

**Special Needs** (e.g. escort; oxygen, wheelchair/oversize wheelchair; etc.):

**Section II** – Certification:

Client is Medicaid Eligible Client is enrolled with the Health Home Lead selected above

Client needs transportation to an alternate location to receive health home services

Care Coordinator Signature/Date: /