



NEW HAMPSHIRE MEDICAID



SCHALLER ANDERSON  
MEDICAL ADMINISTRATORS,  
INCORPORATED

### DOCUMENTATION TO SUPPORT THE USE OF WHEELCHAIR VAN SERVICES

**Wheelchair Van Providers:** To support payment by the NH Medicaid/Healthy Kids-Gold (NH Title XIX) program, this completed, dated and signed form must be retained in the vendor-maintained NH Title XIX recipient's file for six years. Incomplete, undated or unsigned forms will be considered invalid. A completed Form 975 is valid as a certificate of medical necessity for wheelchair van services only for the date span requested in Section 2 of this form. The recipient's NH Title XIX eligibility must be verified each time wheelchair van services are accessed. If the recipient changes wheelchair van providers, the new provider must either obtain a copy of the 975 from the previous wheelchair van provider or have a new 975 completed for the new wheelchair van provider's file.

**SECTION 1 - To be completed by the wheelchair van service provider actually providing the service.**

RECIPIENT NAME: \_\_\_\_\_ RECIPIENT MEDICAID ID#: \_\_\_\_\_

WHEELCHAIR VAN SERVICE VENDOR: \_\_\_\_\_ BUS. PHONE: \_\_\_\_\_

WILL THE WHEELCHAIR VAN SERVICE PROVIDER BE PROVIDING THE WHEELCHAIR DURING TRANSPORT?  
YES \_\_\_\_ NO \_\_\_\_

**SECTION 2 - To be completed and signed by the attending physician, physician assistant, ARNP or registered nurse.** Failure to complete this form in its entirety may result in a delay in securing transportation to medically necessary services for this individual.

Primary diagnosis: \_\_\_\_\_

Secondary diagnosis: \_\_\_\_\_

Request for wheelchair van service is:  a temporary need for an acute condition (90 days or less)  
 a long term need for a chronic condition (up to one year)

Please explain reason for temporary or long term need: \_\_\_\_\_

Date span of services requested: **From:** \_\_\_\_\_ **To:** \_\_\_\_\_

Span of dates must be 90 days or less for acute condition, or no longer than 1 year for chronic condition. A new 975 must be completed for subsequent time periods.

Does this individual require a wheelchair for: Indoor mobility? Yes  No

Outdoor mobility? Yes  No

Does this individual own or currently rent a wheelchair? Yes  No

Considering the individual's medical condition, is s/he able to utilize:  
Public bus transportation (where available)? Yes  No

Transportation by taxi (where available)? Yes  No

Private automobile (without modifications)? Yes  No

**By signing below, you are certifying that the above-noted individual is unable to mobilize without the use of a wheelchair for the time-period listed above, and requires the use of a wheelchair van for transportation to and from medical services.**

\_\_\_\_\_  
Signature of MD, PA, ARNP, RN

\_\_\_\_\_  
Title

\_\_\_\_\_  
Contact Phone Number

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date Signed

**FOR SERVICE LIMIT OVERRIDE USE ONLY (To be completed by wheelchair van provider):**

I am requesting consideration of additional services beyond the 24-trip limit. **NOTE:** Additional services will not be authorized beyond the end date indicated in Section 2, above. Actual authorized covered services may be less than the amount requested. If additional services are determined to be necessary subsequent to this request, a new 975 must be submitted for reconsideration.

**PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL**

*Please submit supporting documentation for verification of above information*

*Approval is a determination that the services requested are medically necessary and not a guarantee of payment.*