



Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth



MassHealth
All Provider Bulletin 192
May 2009

To: All Providers Participating in MassHealth
From: Tom Dehner, Medicaid Director TD
RE: Revised Prescription for Transportation (PT-1) Form

Background

As part of preparation for NewMMIS implementation on May 26, 2009, the prescription for transportation (PT-1) form used by providers on behalf of members to request authorization for transportation to a medical appointment, has been revised. A few changes have been made to the form to reflect updates to the MassHealth transportation regulations.

Changes to the PT-1 Form

The following changes have been made to the PT-1 form.

- Recipient ID is now called member ID, and is 12 characters long instead of 10.
- The provider number is now MassHealth provider ID/service location, and the NPI field is also included.
- Alternate address information is now included in Section 1, along with home and mailing address information.
- Dental third-party administrator has been added to Section 8 as an authorized signature that MassHealth will accept on the form.

The form continues to be fillable online. We encourage you to submit your PT-1 requests electronically instead of using the fax or mail.

Using the New PT-1 Form

You can start using the revised PT-1 form *immediately*.

(continued on next page)

***Requesting a Supply of
the PT-1 Form***

You can request a supply of the PT-1 form online at www.mass.gov/masshealth. Click on Order Provider Publications in the Online Services box.

You can also mail or fax a written request for supplies of this form at the address or fax number below.

MassHealth
ATTN: Forms Distribution
P.O. Box 9118
Hingham, MA 02043
Fax: 617-988-8973

Attached is a sample of the revised PT-1 form.

Questions

If you have any questions about the information in this bulletin, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

PRESCRIPTION FOR TRANSPORTATION FORMPlease indicate the type of request: New form Renewal Increase in visits Alternate pick-up address**Please print or type all information.****1. MassHealth Member Information**

Last name		First name		Date of birth	
Member ID					Tel. no.
HOME ADDRESS (The MassHealth member will be transported to and from this address, unless an alternate pick-up address is listed.)					
Street address		Apt. no.	City/Town		State Zip
ALTERNATE PICK-UP ADDRESS					
Street address		Apt. no.	City/Town		State Zip
MAILING ADDRESS (if different from home address)					
Street address		Apt. no.	City/Town		State Zip

2. MassHealth Provider Information (Section to be completed by the provider requesting transportation.)

Name of treating provider/facility		Tel. no.		Ext.	
Street address		Suite no.	City/Town		State Zip
MassHealth provider ID/service location				NPI	

3. Name and Location of Treating Provider/Facility (Indicate where the MassHealth member will be seen.) Check if same as provider listed in Section 2.

Name of treating provider/facility		Tel. no.		Ext.	
Street address		City/Town		State Zip	
MassHealth provider ID/service location				NPI	
Is the treating facility within the member's locality (city or town of residence, or adjacent city or town)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If No, please justify:					

4. Medical Treatment Type

Please list the MassHealth-covered service(s) that the member is receiving at this location.

5. Duration and Frequency of Treatment

How long will the MassHealth member require these services?	___ week(s)	___ month(s)
How frequently will the MassHealth member be seen for this service?	___ visit(s) per week	___ visit(s) per month

6. Why Transportation Services Are Required

Is there a medical reason why the member (or guardian if accompanying a minor) is unable to use public transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please describe specific medical reason:

7. Other Information

Is a wheelchair van needed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is an escort accompanying the member for assistance with ambulation or to accompany a minor? <input type="checkbox"/> Yes <input type="checkbox"/> No
Specify other transportation needs:

8. Provider/Dental TPA Signature

Signature:	Date:
Please check applicable title: <input type="checkbox"/> MD <input type="checkbox"/> DDS <input type="checkbox"/> RNP <input type="checkbox"/> RNC <input type="checkbox"/> Other (Specify title)	

Do not write below this line · MassHealth use only APPROVED. Authorization expires on: _____ Tracking no.: DENIED. Reason: _____

MassHealth authorized signature: _____ Date: _____

Instructions for Completing the Prescription for Transportation Form

Section 1 – Enter the member’s name, date of birth, MassHealth member ID, telephone number, and home address, including apartment number, if applicable.

In certain circumstances MassHealth may authorize a member to be picked up at an address other than his/her home address. If the member is to be picked up at an alternate address, enter the alternate address information below the home address information. If there is a mailing address that is different from the home address, enter that below the alternate pick-up address.

Section 2 – Enter the provider’s name, telephone number, address, MassHealth provider ID/Service location, and the NPI.

The provider requesting transportation must be a physician, physician’s assistant, nurse midwife, dentist, nurse practitioner, psychologist, or managed-care representative, and an active MassHealth provider.

Section 3 – If the provider is also the treating provider, place a checkmark in the box labeled “Check if same as provider listed in Section 2.” If the treating provider is different from the provider filling out Section 2, enter that provider’s name, telephone number, address and, if known, their MassHealth provider ID Service location, and the NPI.

If the treatment destination is outside of the member’s locality (city or town of residence, or immediately adjacent communities), indicate why the medical care is unavailable to the member within the member’s locality.

Section 4 – Describe the specific medical care that will be provided.

Section 5 – Indicate how many weeks or months the member will require transportation, and how frequently the member will be going per week or per month for the service. MassHealth will not authorize more than six months of transportation for an acute illness, or one year of transportation for a chronic illness. For a single visit, enter “1” week, and “1” visit per week.

Section 6 – Indicate if there is a medical reason that the member (or guardian, in accompanying the member) is unable to use public transportation. Provide the specific physical or mental disability that prevents the member from using public transportation.

Section 7 – Indicate if a wheelchair van or an escort is necessary.

Wheelchair van transportation may be provided for nonemergency medical services for members who use a wheelchair or whose severe mobility impairments prevent them from traveling in a vehicle other than a wheelchair van.

Section 8 – The signature of the physician, dental third-party administrator, physician’s assistant, nurse midwife, dentist, nurse practitioner, psychologist, or managed-care representative is required to process the PT-1 form. The signature certifies that the information contained on the form and any attachments, including medical necessity information (per 130 CMR 450.204) is true, accurate, and complete to the best of the signatory’s knowledge. Any falsification, omission, or concealment of any material fact contained on this form may result in civil penalties or criminal prosecution.

For more detailed information about the MassHealth transportation benefit, consult the MassHealth transportation regulations at 130 CMR 407.000. If you have any questions about completing this form, please call the MassHealth Transportation Authorization Unit at MassHealth Customer Service at 1-800-841-2900.