



2860 S Circle Dr. Suite 239, Colorado Springs, CO 80906  
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**Medical Certification of Transportation Services: Beyond 25 Miles**

The patient's medical provider completes this form which will be used to verify that any trip requested over 25 miles has been confirmed as needed by the member's medical provider. There are no closer providers to this member that can provide needed service are the reasons for submittal. This information can be faxed, emailed or mailed to Transit To Care.

Patient Name \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Patient Health First Colorado ID: \_\_\_\_\_

**Medical Facility Information:**

Medical Provider's Name: \_\_\_\_\_ Facility Name: \_\_\_\_\_

Facility Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Facility Address: \_\_\_\_\_ Suite: \_\_\_\_\_ Specialty: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Explain why patient cannot be seen by a provider closer to the patient's home:

**Agreement and signature:**

I hereby certify that the information contained herein is true and accurate.

Name of Licensed Medical Provider: \_\_\_\_\_ Title: \_\_\_\_\_

Signature of medical facility staff: \_\_\_\_\_ Date: \_\_\_\_\_