Level of Need (LON) Assessment Form- Senior Care Options

WellSense HEALTH PLAN

This form should be completed by the attending Physician or other medical staff, at the direction of the Physician, to determine the level of equipment necessary for patient transportation to doctor's appointments.

Patient Info

First name	Last name	Middle initial

Medicaid ID	Date of birth	Phone	Trip # *(if applicable)*

Street address	City	State	Zip

Medical Necessity

☐ Wheelchair Transportation

Wheelchair Type: ☐ Manual ☐ Electric

Height _____ Weight _____

Patient Self Propels	☐ YES	☐ NO
Patient Self Transfers	☐ YES	☐ NO
Patient Travels w/Oxygen	☐ YES	☐ NO

☐ Stretcher Transportation

Check all that apply to the Patient:

☐ Bed confined

☐ Unable to sit in a chair or wheelchair

☐ Unable to ambulate

☐ Unable to get up from bed without assistance

Special Needs

☐ Cane ☐ Crutches ☐ Walker ☐ Compact Portable Oxygen Tank *(self-administered)*

☐ Service Animal ☐ Attendant / Escort

Note any additional medical conditions and monitoring or support requirement(s) needed to ensure safe transport:

_____

_____

_____

Duration of Level of Need: ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ Permanent

Medical Professional Info

I certify that to the best of my knowledge, the above information is true, accurate and complete and the level of service required for the Patient's transport is medically necessary for the Patient's health.

Phone: 855-833-8125 (TTY: 711)
Fax: 203-375-0511
E-mail: Nteamleads@ctstransit.com

WellSense HEALTH PLAN

Printed Name	NPI #
Signature	Phone #
Title	Date

This form must be received no less than 48 hours prior to the appointment time or transportation cannot be arranged.

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