INSTRUCTIONS

1. Print or type clearly. 2. Transportation must be by least expensive alternative which provides the necessary safeguards.
3. Must be submitted within 3 months of service. 4. Receiver certification is not an indication of admittance.

TRANSPORTATION AUTHORIZATION CERTIFICATE

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

FOR BUSINESS USE ONLY
I.D. NUMBER

MHCC-15 REV.11/06

1. IDENTIFICATION/AUTHORIZATION CERTIFICATION (To be completed by PHYSICIAN, RECEIVER, and/or PROVIDER for ALL transportation)

PATIENT NAME (Last)	(First)	(Middle)	**PATIENT BIRTH DATE**
ADDRESS (NO. AND Street)	(City or Town)	(State) (Zip)	**PATIENT SOCIAL SECURITY NUMBER**

TRANSPORTATION PROVIDED				
	FROM	**FACILITY CODE**	**TOWN CODE**	**TIME DISPATCHED** **AM / PM**
	TO	**FACILITY CODE**	**TOWN CODE**	**TIME ARRIVED** **AM / PM**

REASON FOR TRANSPORTATION (Must be filled out)	TRANSPORTATION MUST BE TO A STATE OPERATED INPATIENT FACILITY			
	1. PSYCHIATRICALLY ☐ **DISABLED PATIENT** 17a-502 (Complete lines 1,2 and 4 below)	**2. VOLUNTARY PSYCHIATRICALLY** ☐ **DISABLED PATIENT** (Complete lines 3 and 4 below)	**3. EMERGENCY SUBSTANCE** ☐ **ABUSE TREATMENT** 17a-684 (Complete lines 1,2 and 4 below)	**4. VOLUNTARY SUBSTANCE** ☐ **ABUSE TREATMENT** (Complete lines 3 and 4 below)

1. TRANSPORTATION	**TYPE OF TRANSPORATION AUTHORIZED** (Examining physician must check one)		
	☐ **COMMERCIAL INVALID COACH**	☐ **AMBULANCE**	(specify) ☐ **OTHER**

2. PHYSICIAN	**DATE** (Mo., Day, Yr.)	**CONN. MEDICAL LICENSE NO.**	**SIGNED:** (Examining physician)

1. TREATMENT PROVIDER CERTIFICATION	Provider hereby certifies that patient named above requested the transportation provided.	**SIGNED:** (Authorized provider representative)

2. RECEIVING FACILITY CERTIFICATION

I hereby certify that ______________________________________ was transported to ____________________________________ for the primary presenting

Name of Patient — Name of Facility

problem of substance abuse or dependence or psychiatric disability by ________________________________ on ___________ at ___________ ☐ AM ☐ PM

Name of Ambulance Company — Date — Time

I further certify that prior to transporting the patient, the transportation provider obtained approval for transport from this facility.

RECEIVER CERTIFICATION	**DATE** (Mo., Day, Yr.)	**Signed:** (Receiving facility representative)
	PRINTED NAME OF AUTHORIZED OFFICIAL:	

3. AMBULANCE COMPANY CERTIFICATION (To be completed for ALL transportation)

I certify that a reasonable attempt was made to obtain payment from the transported patient and to determine that no third party is liable for payment of the transportation expenses. Evidence of these efforts shall be presented to DMHAS upon request.

SIGNATURE OF AUTHORIZED OFFICIAL OF AMBULANCE COMPANY:	**DATE:**

3. BUREAU OF COLLECTION SERVICES (For Bureau of Collections Services ONLY)

Did patient have ability to pay at time of admission? ❍ YES ❍ NO (If "YES", provide financial information below)

RECOMMENDED BY (Name - PRINT OR TYPE)	**TITLE:**	
FIELD OFFICE	**DATE** (Mo., Day, Yr.)	**SIGNED:**