



The Pinellas County Metropolitan Planning Organization (MPO), acting as the Community Transportation Coordinator (CTC) for Pinellas County, administers Medicaid Non Emergency Transportation (NET) services for eligible Medicaid recipients. Depending on the number of anticipated Medicaid trips per month and the recipient's ability to access the public transportation system, recipients are either given a 31-day bus pass or transportation via taxi cab or wheelchair van.

You have received this form because you have been assigned to the Medicaid bus pass program, based upon the number of medical trips you anticipate needing this month, but have indicated that you are unable to ride the bus. In order for us to determine if transportation by taxi cab or wheelchair van would be more appropriate, please complete the top section of the form below and have your physician complete the bottom portion. Once complete, the form should be mailed or faxed back to the address/number located at the bottom of the form.

Medicaid Recipient Information (to be completed by recipient):

Name: _____ Phone: _____
Street Address: _____
City: _____ Zip: _____
Medicaid Number: _____

Physician Certification of Inability to Utilize the Bus System

Form must be completed by a licensed physician who is familiar with the Medicaid Beneficiary's disability. The CTC is contractually obligated to provide the most appropriate and cost effective form of transportation for eligible Medicaid recipients to Medicaid compensable appointments. For recipients who are able to utilize the bus system and have multiple medical appointments each month, the most cost effective transportation is the bus system. After a beneficiary has been assigned to the bus pass program, the can only receive transportation via taxi cab or wheelchair van is a physician certifies that due to a medical diagnosis or disability the person is unable to access or utilize the bus system.

Physician Name: _____ License #/State: _____
Office Address: _____
Telephone Number: _____

Does the Medicaid recipient have a medical condition or disability that would prevent them from accessing and/or utilizing the bus system? Yes _____ No _____

Describe the medical condition or disability and how it prevents the recipient from accessing and/or utilizing the bus system: _____

Is the condition/disability permanent? Yes _____ No _____

If No, in your medical opinion, how long will the condition/disability prevent the beneficiary from accessing/utilizing the regular bus system? _____ Month(s)

I hereby certify that the medical information provided above is true and correct.

Signature of Physician: _____ Date: _____

Fax or mail completed form to:
Community Transportation Services
13825 Icot Blvd #613
Clearwater, FL 33760
FAX: (727) 544-0171
Phone: 727-545-2100