CONDUENT

MEMBER INFORMATION	REFERRING PROVIDER INFORMATION
Member Name: _____ *(Last, First, MI)*	Referring Provider's Name: _____
Alaska Medicaid Member ID: _____	Provider Medicaid ID or NPI (optional): _____
Date of Birth *(MM/DD/YY)*: _____ Age: _____	Phone Number: _____ Ext. _____

RECEIVING PROVIDER INFORMATION	Type of Request	Documentation Attached:
Receiving Provider's Name: _____	☐ Initial visit with provider	☐ POC
Provider Medicaid ID or NPI (optional): _____	☐ Follow-up visit with provider	☐ Chart Notes
Phone Number: _____ Ext. _____		

CLINICAL INFORMATION *(This section MUST be completed by the referring or receiving provider.)*

Date of Last Physician Visit Related to Diagnosis	Diagnosis Description and Date of Diagnosis (*Related to need for travel.)*

Answer COMN Questions 1 – 4 *(Y = Yes, N = No)*

1. List procedures the member is traveling for, including date(s), provider name and procedure code(s). If travel is related to an Inpatient stay, please add the dates member is going to be inpatient. Ex. 6/22/2022 – COVID Test (U0002), 6/24/2022 – 6/28/2022 Tonsillectomy (42820)

2. Can the services the member is traveling for be provided locally? If No, explain why not. (Y) or (N)

   If Yes, explain why we are bypassing local providers. In other words, what is the clinical rationale for the referral you have chosen compared to other possibilities?

   If Yes, list local and/or in-state providers who have been consulted along with the dates of those consultations.

3. Are there special circumstances (social dynamics, excessive time between appointments, etc.) that need to be taken into account for this travel? If Yes, explain. (Y) or (N)

4. Can the services be provided via telehealth? If No, explain why not. (Y) or (N)

ATTESTATION, SIGNATURE AND DATE OF REQUESTING PROVIDER

A Healthcare provider who attests to the medical necessity of the travel, who knowingly or willfully makes or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I certify that I have reviewed the travel request and that I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

_____ Printed Name of Requesting Provider

_____ COMN Certification Period (Not to Exceed 1 Year)

_____ Signature of Requesting Provider

_____ Date

Authorization does not guarantee payment. Payment is subject to member's eligibility. Check that identification card is current before rendering services.

EXHAUST INFORMATION
Alaska Medicaid covers transportation and accommodation services to the closest most appropriate enrolled Alaska Medicaid provider that can perform the medically necessary services. If the service(s), including if a similar service(s), can be performed closer to the member's home community, the referring provider must describe (1) why those service(s) do not meet the needs of the member and (2) why the facility the member is traveling to results in the highest value clinical care and best use of Alaska Medicaid resources. Applicable Regulations 7 AAC 105.100, 7 AAC 120.405, 7 AAC 120.410, 7 AAC 120.425, 7 AAC 120.430

Certification of Medical Necessity Instructions

Member Information	Referring Provider Information
Member Name: Enter the member's last name, first name and middle initial. **Alaska Medicaid Member ID:** Enter the Alaska Medicaid Member ID number. **Date of Birth:** Enter the member's date of birth using the calendar feature or a MM/DD/YY format. **Age:** Enter the age of the member.	**Referring Provider's Name:** Enter the referring provider's last name, first name, and middle initial. **Provider Medicaid ID or NPI:** Enter the referring provider's Medicaid ID or NPI number. **Phone Number & Ext.:** Enter the referring provider's contact phone number and extension. **Type of Request:** Select the option that most appropriately reflects the reason for the request.
Receiving Provider Information	**Clinical Information** *This section **must** be completed by the referring provider.*
Receiving Provider's Name: Enter the receiving provider's last name, first name, and middle initial. **Provider Medicaid ID or NPI**: Enter the receiving provider's Medicaid ID or NPI number**.** **Phone Number & Ext.:** Enter the receiving provider's contact phone number and extension. **Type of Request: Select the option that most appropriately reflects the reason for the request.**	**Date of Last Provider visit Related to Diagnosis:** Enter the date the patient was last seen by their referring provide regarding diagnosis that prompted the travel request. **Answer COMN Questions 1-4**: Indicate the answer that most accurately reflects the member's condition, current status, and medical records as applicable. For question 2, please attach pertinent medical records for all providers involved in the decision for the travel need.
Attestation, Signature, and Date of Referring Provider: Enter signature of the referring provider submitting LOMN request and date signed. The signature must be that of the professional who, by signing the form, attests that the contents of the completed form is accurate and meets Alaska Medical Assistance program requirements. **Forward this form to:** Conduent Service Authorization, PO Box 240808, Anchorage, AK 99524-0808	

ADDITIONAL DOCUMENTATION (Please use this page to complete questions 1 - 4 if more space is needed. Make sure to notate which question corresponds to the information provided in this section.)