## Medical Assistance Transportation Program Out of Service Area Request Form

<b>Ecolane</b>	ID#
----------------	-----

\* THIS REQUEST MUST BE COMPLETED BY A PHYSICIAN & ALLOW A MINIMUM OF 48 HOURS FOR PROCESSING \*

MA out of service area transportation may be requested to allow eligible riders to access medical services outside of their service area of residence if: (1) the qualified MA enrolled providers are unavailable within their service area of residence or (2) a unique medical condition prohibits treatment within their service area of residence.

Rider's Service Provider:  REFERRED MEDICAL LOCATION INFORMATION (Please print)  Treating Medical Location Name:  Treating Medical Location Address:  Name of Treating Physician:  Primary care provider, explain:  Specialist, explain:  Length of time request is needed (6 months maximum)  Is the requested provider a qualified MA provider?  PHYSICIAN AFFIRMATION OF INFORMATION (Please print)  Physician Name:  Title:  Medical Location Name:  Phone:  Affirmation of information: I hereby certify that, to the best of my knowledge, the Information contained herein is true, correct, and complete.  Signature  Date  For OFFICE USE ONLY		CLIENT INFORMATION (Please print)		
REFERRED MEDICAL LOCATION INFORMATION (Please print)  Treating Medical Location Name:  Treating Medical Location Address:  Name of Treating Physician:  Primary care provider, explain:  Specialist, explain:  Length of time request is needed (6 months maximum)  Security and Maximum a	Rider Name:		/ Date of Birth//	
Treating Medical Location Name:			□ '; GTRIde	
Treating Medical Location Address:    Name of Treating Physician:		REFERRED MEDICAL LOCATION IN	INFORMATION (Please print)	
Name of Treating Physician:	Treating Medical Location Nam	e:		
1. What type of medical service is being sought outside of the service area:    Primary care provider, explain:	Treating Medical Location Addr	ress:		
Primary care provider, explain:  Specialist, explain:  2. Length of time request is needed (6 months maximum)	Name of Treating Physician:		NPI#	
Specialist, explain:  2. Length of time request is needed (6 months maximum)    3 Months    6 Months  3. Is the requested provider a qualified MA provider? yes no  4. Is the service to be provided a MA covered service? yes no  PHYSICIAN AFFIRMATION OF INFORMATION (Please print)  Physician Name: Title:  Medical Location Name: Title:  Phone: Affirmation of information: I hereby certify that, to the best of my knowledge, the information contained herein is true, correct, and complete.  Signature Date  Mail to LANTA, Out of Service Area Request, 60 W Broad St. Suite 100, Bethlehem, PA 18018 or fax to 484-633-3625 or scan and email to lantavan@lantabus-pa.gov.	1. What type of medical service	ce is being sought outside of the so	service area:	
2. Length of time request is needed (6 months maximum)	Primary care provider, <i>exp</i>	plain:		
3. Is the requested provider a qualified MA provider? yes no  4. Is the service to be provided a MA covered service? yes no  PHYSICIAN AFFIRMATION OF INFORMATION (Please print)  Physician Name: Title:  Medical Location Name: Title:  Medical Location Name: To the service and complete.  Affirmation of information: I hereby certify that, to the best of my knowledge, the information contained herein is true, correct, and complete.  Signature Date  Mail to LANTA, Out of Service Area Request, 60 W Broad St. Suite 100, Bethlehem, PA 18018 or fax to 484-633-3625 or scan and email to lantavan@lantabus-pa.gov.	Specialist, explain:			
Affirmation of information: I hereby certify that, to the best of my knowledge, the information contained herein is true, correct, and complete.  Signature	2. Length of time request is need	eded (6 months maximum) 🗀 🤅	3 Months	
PHYSICIAN AFFIRMATION OF INFORMATION (Please print)  Physician Name:	3. Is the requested provider a q	ualified MA provider? yes	no	
Physician Name: Title:  Medical Location Name:  Phone:  Affirmation of information: I hereby certify that, to the best of my knowledge, the information contained herein is true, correct, and complete.  Signature Date  Mail to LANTA, Out of Service Area Request, 60 W Broad St. Suite 100, Bethlehem, PA 18018 or fax to 484-633-3625 or scan and email to lantavan@lantabus-pa.gov.	4. Is the service to be provided	a MA covered service? yes _	no	
Medical Location Name:  Phone:  Affirmation of information: I hereby certify that, to the best of my knowledge, the information contained herein is true, correct, and complete.  Signature  Date  Mail to LANTA, Out of Service Area Request, 60 W Broad St. Suite 100, Bethlehem, PA 18018 or fax to 484-633-3625 or scan and email to lantavan@lantabus-pa.gov.		PHYSICIAN AFFIRMATION OF IN	NFORMATION (Please print)	
Medical Location Name:  Phone:  Affirmation of information: I hereby certify that, to the best of my knowledge, the information contained herein is true, correct, and complete.  Signature  Date  Mail to LANTA, Out of Service Area Request, 60 W Broad St. Suite 100, Bethlehem, PA 18018 or fax to 484-633-3625 or scan and email to lantavan@lantabus-pa.gov.	Physician Name:	<del>_</del>	Title:	
Affirmation of information: I hereby certify that, to the best of my knowledge, the information contained herein is true, correct, and complete.  Signature				
Signature	Phone:			
Mail to LANTA, Out of Service Area Request, 60 W Broad St. Suite 100, Bethlehem, PA 18018 or fax to 484-633-3625 or scan and email to <a href="mailto:lantavan@lantabus-pa.gov">lantavan@lantabus-pa.gov</a> .	<b>Affirmation of information:</b> <i>I he correct, and complete.</i>	ereby certify that, to the best of m	ny knowledge, the information contained herein is true,	
and email to lantavan@lantabus-pa.gov.	Signature		Date	
FOR OFFICE USE ONLY			e 100, Bethlehem, PA 18018 or fax to 484-633-3625 or scan	
		FOR OFFICE US	JSE ONLY	
Status: Date Processed: Initials:		55		

Revision Date: 3/2025