Medical Assistance Transportation Program
Out of Service Area Request Form

_____
Ecolane 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.

CLIENT INFORMATION *(Please print)*

Rider Name: _____ Date of Birth _____ / _____ / _____

Rider's Service Provider: ☐ LANtaVan ☐ CT Shared Ride

REFERRED MEDICAL LOCATION INFORMATION *(Please print)*

Treating Medical Location Name: _____

Treating Medical Location Address: _____

Name of Treating Physician: _____ NPI#_____

1. What type of medical service is being sought outside of the service area:

☐ Primary care provider, *explain*: _____

☐ 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:_____

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.

FOR OFFICE USE ONLY		
Status:	Date Processed:	Initials:

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