MEDICAL REQUEST FOR OVERNIGHT TRAVEL

South Carolina

The Medical Request for Overnight Travel is required for the approval of ancillary services for South Carolina Medicaid members with in-state overnight travel needs.

Medicaid Member Name:	Medicaid Number:	
Date of Birth:	Phone Number:	
Physical Address:		
City:	State:	Zip Code:

Date of Appointment:	Appointment Time:	
Facility Name:	Phone Number:	
Fax Number:	Treating Physician:	
Physical Address:		
City:	State:	Zip Code:
Treatment Type:		

Please explain why the member needs to stay overnight:

If an escort is being requested to travel with the member, please complete the Medical Certification for Escort Form and attach. If the request is for a minor child, one adult escort (parent or guardian) will be automatically approved.

I certify that it is medically necessary for this patient to receive treatment at our facility and other requested related travel services. This certification is being provided to the best of my knowledge and within my professional scope.	
Signature:	Date:
Printed Name:	Title:

For LogistiCare Use Only	
☐ Approved (Reference Number: _____)	☐ Denied (Reference Number: _____)
Date Received:	Date Response Sent:
Facility Representative Signature:	

Fax completed form and any accompanying documentation to (877) 601-0530.