Medicaid Transportation Complaint/Referral Form

This information is directed to the NJ Division of Medical Assistance and Health Services (DMAHS) staff assigned to monitor the Medicaid transportation vendor Logisticare.

Date of complaint ____/____/_____

Name of transportation company____

Name of Skilled Nursing Facility (SNF)____

Name of Resident ____

Transportation was booked by (check one)
___ staff ___ resident ___ family/responsible party ___other

Scheduled pick up time at SNF ____________ am / pm

Actual time of pick up at SNF ____________ am / pm

Appointment time ____________ am / pm **Arrival at appointment time**___________ am/pm

Return to SNF scheduled pick up time ___________ am/pm

Actual pick up time ________ am/pm **Return to SNF time** ___________ am/pm

Type of Complaint: (Check all That Apply)
___ Late Pick Up at Facility **How late?** ____ hour/s ____ minutes
___ No Show at Facility
___ Late Pick Up For Return **How late?** ____hour/s ____minutes
___ No Show for Return
___ Other: ____

Additional concerns, related to transportation, which may have negatively impacted the resident's quality of life: (e.g. – appointment cancelled – appointment had to be rescheduled – problems with behavior of driver – loss of needed medical care – problem reaching Call Center or any other concerns).

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Name of person filing complaint: ____

Relationship: (e.g. resident, family member, N.H. staffer) ______________________________________

Resident or responsible party contact information____

Resident/ Responsible Party has been advised of this referral to DMAHS, Logisticare Medicaid Unit ____ Yes

Please fax this form: Attention Medicaid Unit 866-527-9835