# Transport DC Dialysis Exemption Form

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| PART A: TO BE COMPLETED BY CUSTOMER | | | | |
| Transport DC Customer Info: | | | | |
| First Name | |  | | |
| Last Name | |  | | |
| MetroAccess ID | |  | | |
| Home Address | |  | | |
| City/State/Zip | |  | | |
| Primary Phone | |  | Cell Phone |  |
| Email | |  | | |
| Primary Dialysis Center Info: | | | | |
| Name | |  | | |
| Street Address | |  | | |
| Main Phone | |  | Email (if available) |  |
| Website | |  | | |
| Email |  | | | |
|  | | | | |
| Secondary (or possible alternative) Dialysis Center Info: | | | | |
| First Name | |  | | |
| Street Address | |  | | |
| Main Phone | |  | Email (if available) |  |
| Website/Email | |  | | |
|  | |  | | |

**Medical Release – MUST BE SIGNED BY CUSTOMER**

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|  | I, authorize the healthcare provider completing this application to release to the DC Department of For-Hire Vehicles the protected health information regarding my disability that necessary in order to verify my eligibility for dialysis transportation, as indicated on Part B of this application. I also authorize the release of further information should it be necessary for this application for a period of sixty (60) days from the date of my signature on Part A of this application.  Transport DC Customer Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Part B: This section must be completed by your health care provider and must be signed by one of the following qualified medical professionals: physician, physician’s assistant or certified nurse practitioner.**   1. Name of Health Care Provider: *(Please print)* 2. Phone: 3. License Number/State Issued: 4. Street Address & Suite Number: 5. City, State, Zip: 6. Specialization: 7. Does this patient require dialysis treatment? \_\_\_ Yes \_\_ No 8. If yes, how many times a week is dialysis required for this patient? \_\_\_\_\_\_\_\_ 9. Written Diagnosis(es) and ICD-9CM and/or DSM Code(s) (why the patient requires dialysis):   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Please indicate how long do you anticipate that the patient will require dialysis treatment?   I certify that I have completed the questions in Part B and that the information provided is correct.  ***Original Signature of Physician/Healthcare Provider*** (Note: Must be original hand signature in blue ink, not signature stamp)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***Date*:** False certification may be reported to the licensing agency under District of Columbia Code Annotated, Section 2-3305.15, Code of Virginia 54. 1-2915, or Maryland Health Occupations Code Annotated 14-404 or appropriate code for state of license. DFHV reserves the right to: (1) verify the validity of the license of the health care provider providing the certification, (2) make the final determination on an applicant’s eligibility for a dialysis transportation exemption under Transport DC and (3) retain a copy of this application form. |  |

**Note to the Transport DC Customer: This form is subject to verification for eligibility for dialysis transportation under the Transport DC Program. The form can be submitted in the following ways:**

By Mail: Transport DC

Department of For Hire Vehicles

2235 Shannon Place SE Suite 3001

Washington, DC 20020

By Email: transportDC@dc.gov