Wheelchair Van Medical Necessity Certificate

_____ Required the use of Medical Wheelchair Van
(Patient name)

transportation on _____ because of _____.
(Date/date range) (Indicate PHYSICAL Reason for transport)

_____
(Signature of medial professional)

_____
(Date signed)

M.A.A.S. Po Box 350, Greensburg, PA 15601 Phone #: (724) 837-6134 Fax #: (724) 834-2810