DSS-NEMT-971 04/2024

For NEMT Staff use only
Claim #

SOUTH DAKOTA MEDICAID
NON-EMERGENCY MEDICAL TRAVEL (NEMT) REIMBURSEMENT FORM - OVERNIGHT TRIP -

- To Be Returned After Your Trip –

TO BE FILLED OUT BY RECEPTIONIST, NURSE, OR DOCTOR

MEDICAL PROVIDER All fields MUST be completed
If the recipient has multiple appointments, please attach an appointment verification and a purpose of visit for each appointment from the medical facility or print a SD Medicaid Non-Emergency Medical Travel Appointment Verification document online at https://dss.sd.gov/medicaid/recipients/title19transportation.aspx and take it with you to the medical appointments.

Appointment:		**Admission:**		**Discharge:**	
Date:	Time:	Date:	Time:	Date:	Time:
Was this appointment at an outreach clinic? ☐ Yes ☐ No		Billing NPI:		Service NPI:	
Medical Facility Name:				Phone Number:	Ext.
Address:					
Doctor's Name:		Purpose of Visit:			
Medicaid Covered Service: ☐ Yes ☐ No					
Do you have a referral on file from the recipient's PCP/HHP provider? ☐ Yes ☐ No					
If travel was out of state, is there an Out of State Prior Authorization in place for the dates above? ☐ Yes ☐ No					

PHARMACY, DURABLE MEDICAL EQUIPMENT, AND OPTICAL SUPPLY ONLY

☐ No delivery available ☐ First fill of a new prescription ☐ Equipment fitting/adjustment

Signature: _____ Date: _____
(Receptionist, Nurse, or Doctor)

TO BE FILLED OUT BY RECIPIENT, PARENT OR GUARDIAN

TRIP INFORMATION All fields All fields MUST be completed

Departure Date (mm/dd/yyyy):	Return Date (mm/dd/yyyy):
Is the recipient currently Inpatient? ☐ Yes ☐ No	Is this a continuation for an ongoing trip? ☐ Yes ☐ No

RECIPIENT INFORMATION All fields MUST be completed

Recipient Name:	Phone Number:
Medicaid Number:	Date of Birth (mm/dd/yyyy):
Recipient Mailing Address:	

Did any additional recipients travel and had a medical appointment(s) during this trip? ☐ *Yes* ☐ *No If yes, please provide details on a separate paper.*

TRAVEL POINTS All fields MUST be completed
Enter your trip details below. List all stop(s) necessary to pick-up or drop-off a recipient(s) or for overnight lodging. (Do not include stops for food, gas, etc.) For example, departure information should reflect the recipient's city of residence as the starting location and the city of the medical appointment(s) as the ending location. Return information should reflect the city of the medical appointment(s) as the starting location and recipient's city of residence as the ending location.

Are you requesting mileage reimbursement? ☐ Yes ☐ No

Does this trip include stops in more than one city? ☐ Yes ☐ No

Due to medical necessity, did you use a driver from outside your city of residence to transport you to or from your medical appointment? ☐ Yes ☐ No If yes (documentation required), list your driver's city of residence. _____

Departure Information

Starting Location (City, State):	Ending Location (City, State):
Mode of Travel: ☐ Air/Ground Ambulance ☐ Bus ☐ IHS Van ☐ Personal Vehicle ☐ Shriner's Van ☐ Transit Provider ☐ Other_____	

Return Information

Starting Location (City, State):	Ending Location (City, State):
Mode of Travel: ☐ Air/Ground Ambulance ☐ Bus ☐ IHS Van ☐ Personal Vehicle ☐ Shriner's Van ☐ Transit Provider ☐ Other_____	

Do you have miscellaneous expenses to report? ☐ Yes ☐ No
If yes, Expense Type: ☐ Public Transportation ☐ Parking Fees ☐ Luggage Fees ☐ Other _____ Amount: $_____

LODGING All fields MUST be completed
Lodging information MUST be entered for every day of overnight travel. If your trip includes more than three nights of lodging, please complete the remaining nights on the Additional Lodging Form, available online at https://dss.sd.gov/medicaid/recipients/title19transportation.aspx

Date (mm/dd/yyyy):

Where did Recipient stay?	Where did Escort stay?

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☐ Hotel (receipt required) ☐ Friend/Family City: _____State: _____ ☐ Inpatient Hospital Stay ☐ Non-Profit ☐ Other_____ ☐ Can't remember	☐ Hotel (receipt required) ☐ Friend/Family City: _____State: _____ ☐ Inpatient Hospital Stay ☐ Non-Profit ☐ Other: _____	☐ Home City: _____State: _____ Mode of Travel: _____ ☐ Can't remember ☐ No Escort
	Did the Escort Travel home and back the same day? ☐ Yes ☐ No If yes, what is the mode of travel? _____	

Date (mm/dd/yyyy):

Where did Recipient stay?	Where did Escort stay?	
☐ Hotel (receipt required) ☐ Friend/Family City: _____State: _____ ☐ Inpatient Hospital Stay ☐ Non-Profit ☐ Other_____ ☐ Can't remember	☐ Hotel (receipt required) ☐ Friend/Family City: _____State: _____ ☐ Inpatient Hospital Stay ☐ Non-Profit ☐ Other: _____	☐ Home City: _____State: _____ Mode of Travel: _____ ☐ Can't remember ☐ No Escort
	Did the Escort Travel home and back the same day? ☐ Yes ☐ No If yes, what is the mode of travel? _____	

TRAVEL ASSISTANCE All fields MUST be completed

Did you receive financial assistance from another source for this medical trip? ☐ Yes ☐ No
*Examples include (but are not limited to): Check/Cash, Gas Vouchers, Meal Passes, Lodging Assistance

Name of Organization:	Phone #:
Mailing Address:	
Type of Assistance: ☐ Cash ☐ Meals ☐ Lodging ☐ Transported Recipient ☐ Other	
Amount of Assistance Received: $	

PAYMENT PROVIDER ***(For the family)*** All fields MUST be completed
If you do not have a provider number for the person you would like to pay, please have them enroll with NEMT at https://dss.sd.gov/nemt or have them complete an NEMT Payment Authorization Form, available at your local DSS office or online at https://dss.sd.gov/Medicaid/recipients/Non-Emergency Medical Travel/NEMT Forms.

Provider Number:
(The NEMT Provider Number is located at the top left-hand corner of the Paid Claim Statement.)

Provider First Name:	Provider Last Name:	
Provider Mailing Address:		
Provider City:	Provider State:	Provider Zip:

FINAL SUBMISSION Please submit your appointment verification with this form. Appointment verification along with any additional supporting documentation is required in order to process your claim. Gas and meal receipts are not required.

I attest that the individual receiving mileage reimbursement and/or the individual driver for this medical trip possessed a valid driver's license during the dates traveled and that the individual receiving mileage reimbursement and/or the induvial driver for this medical trip is not excluded from participation in any federal health care program or is not listed on the exclusion list of the Department of Health and Human Services Office of Inspector General (https://exclusions.oig.hhs.gov/). NOTE: This statement is excluded if recipient was transported by an entity/organization.

I understand that I will be reimbursed only to the closest provider capable of providing the necessary services. I certify that the information is correct to the best of my knowledge and any attached receipts represent eligible expenses. I understand that there are penalties for fraudulently submitting claims and misrepresenting receipts for reimbursement.

I am related to the individual(s) in the Recipient Section of this form. Please select one of the following:
☐ Recipient (self) ☐ Parent ☐ Guardian *(Court ordered guardianship papers must be submitted to or on file with NEMT.)*

PRINTED NAME: _____

SIGNATURE: _____ DATE: _____

Please return this form by mail, email or fax along with any necessary documentation or receipts to:

Department of Social Services
Finance/EBT
700 Governor's Drive
Pierre, SD 57501

Local Phone Number: (605) 773-6527
Toll Free Number: 866-403-1433
Fax Number: (605) 773-8461
Email: dss.ebtstateoffice@state.sd.us

Claims may also be submitted through our online portal at https://dss.sd.gov/nemt