DSS-NEMT-973 04/2024

*For NEMT Staff use only*
Claim #

# SOUTH DAKOTA MEDICAID NON-EMERGENCY MEDICAL TRAVEL APPOINTMENT VERIFICATION FORM

**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.

***Complete one section per appointment***

| Recipient Name: | Medicaid Number: |
|---|---|

*****TO BE FILLED OUT BY RECEPTIONIST, NURSE, OR DOCTOR*****

| **Appointment:** | | **Admission:** | | **Discharge:** | |
|---|---|---|---|---|---|
| Date: | Time: | Date: | Time: | Date: | Time: |
| Was this appointment at an outreach clinic? ☐ Yes ☐ No | | Billing NPI: | | Servicing NPI: | |
| Medical Facility Name: | | | | Phone Number: | Ext. |
| Address: | | | | | |
| Doctor's Name: | | Purpose of Visit: | | | |
| Is this a 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: _____ (Receptionist, Nurse, or Doctor) | | | | Date: _____ | |

| Recipient Name: | Recipient ID #: |
|---|---|

*****TO BE FILLED OUT BY RECEPTIONIST, NURSE, OR DOCTOR*****

| **Appointment** | | **Admission** | | **Discharge** | |
|---|---|---|---|---|---|
| Date: | Time: | Date: | Time: | Date: | Time: |
| Was this appointment at an outreach clinic? ☐ Yes ☐ No | | Billing NPI: | | Servicing NPI: | |
| Medical Facility Name: | | | | Phone Number: | Ext: |
| Address: | | | | | |
| Doctor's Name: | | Purpose of Visit: | | | |
| Is this a 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: _____ (Receptionist, Nurse, or Doctor) | | | | Date: _____ | |

| Recipient Name: | Recipient ID #: |
|---|---|

*****TO BE FILLED OUT BY RECEPTIONIST, NURSE, OR DOCTOR*****

| **Appointment** | | **Admission** | | **Discharge** | |
|---|---|---|---|---|---|
| Date: | Time: | Date: | Time: | Date: | Time: |
| Was this appointment at an outreach clinic? ☐ Yes ☐ No | | Billing NPI: | | Servicing NPI: | |
| Medical Facility Name: | | | | Phone Number: | Ext: |
| Address: | | | | | |
| Doctor's Name: | | Purpose of Visit: | | | |
| Is this a 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: _____ (Receptionist, Nurse, or Doctor) | | | | Date: _____ | |