TRANSPORTATION PROVIDER VEHICLE DETAILS

Provider Name:_____

Provider NPI:_____ Application # (if applicable): _____

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Background: There are different types of transportation providers and the eligibility requirements vary based on the type pursuant to ARSD Chapter 67:16:25.

A community transportation provider is a governmental entity or is registered as a nonprofit organization with the South Dakota Secretary of State that desires to furnish transportation to and from medical services for a recipient. Vehicles utilized must be licensed with commercial or exempt vehicle license plates.

A wheelchair transportation provider is an entity that uses specially designed and equipped vehicles to furnish transportation to and from medical services to recipients who are confined to wheelchairs or require use of a stretcher.

An ambulance provider is licensed by the SD Department of Health under the provisions of article 44:05, or if located outside of South Dakota is enrolled with the other state's Medicaid program to provide ambulance service.

Instructions: *Populate the requested data below to provide a description of the vehicle(s) that will be used to transport SD Medicaid recipients. Complete a separate form for each vehicle that the entity or organization utilizes to provide transportation to Medicaid recipients and populate the total number of Provider Vehicle Details forms at the top to ensure all forms are received.*

To be completed by provider:

License Type (circle one): Commercial Exempt

License Plate Number: _____

Vehicle VIN or Serial Number: _____

Make:_____Model:_____

Body Type: _____ Year: _____

Physical Address of the Vehicle: _____

City/Town: _____ State:_____ Zip Code: _____

Garage Location (if applicable):_____

City/Town: _____ State:_____ Zip Code: _____

I attest that the information submitted above has been completed accurately, to the best of my knowledge and that failure to appropriately disclose information is reason to deny an application to be a provider with South Dakota Medicaid or terminate an existing provider agreement with South Dakota Medicaid.

Completed by:_____ Date:_____
(Signature of Authorized Official)

Printed Name:_____