DSS-OS-950 05/15

TITLE XIX MEDICAL TRANSPORTATION REIMBURSEMENT FORM

- To Be Returned After Your Trip –

-See reverse side for program guidelines, form instructions and contact/mailing information-

*****TO BE FILLED OUT BY RECIPIENT, PARENT OR GUARDIAN*****

SECTION 1: MEDICAID RECIPIENT INFORMATION

(If there are additional family members that traveled and had a medical appointment, please list them on a separate sheet of paper and attach to this form.)

Name:	
Date of Birth:	Medicaid #:
Address:	Phone #:

SECTION 2: PAYMENT INFORMATION

Payment Goes To:	Phone #:
Mailing Address:	

Have you completed a NEMT Payment Authorization form?

☐ Yes. Your reimbursement will be deposited after your claim has been processed. Please allow 6-8 weeks for processing.

☐ No. Before reimbursement can be made, you MUST complete and return a NEMT Payment Authorization Form along with any required documentation. NEMT Payment Authorization Forms can be found at any local DSS Office, online at https://dss.sd.gov/medicaid/recipients/title19transportation.aspx or by calling 1-866-403-1433.

SECTION 3: FINANCIAL ASSISTANCE

(If you received financial assistance from more than one organization, please list them on a separate sheet of paper and attach to this form.)

Did you receive financial assistance from another source for this medical trip? ☐ YES ☐ NO

* **Examples include (but are not limited to): Check/Money, Gas Vouchers, Meal Passes, Lodging Assistance

Name of Organization:	Phone #:
Mailing Address:	

Type of Assistance: ☐ Check/Money ☐ Gas Voucher ☐ Meal Passes ☐ Lodging ☐ Other

Amount of Assistance:

SECTION 4: TRIP INFORMATION

From (City):	To (City):
Departure Date:	Return Date:

Mode of Transportation: ☐ Personal Vehicle ☐ Hospital Transportation Service ☐ Shriner's Van

☐ Transportation provider in my community _____ ☐ Other _____

Lodging Information:

Recipient Lodging:	Driver/Escort Lodging:
☐ Motel (receipt required)	☐ Motel (receipt required)
☐ Family/Friend (no receipt required)	☐ Family/Friend (no receipt required)
☐ Inpatient Hospital Stay (no receipt required)	☐ Stayed in hospital (no receipt required)
☐ Other _____	☐ Other _____

SECTION 5: SIGNATURE

I understand that I will be paid mileage only to the closest provider capable of providing the necessary services. I certify that the above 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 for reimbursement and misrepresentation of receipts submitted for payment.

SIGNATURE: _____ **DATE:** _____

(Recipient, parent, or guardian)

SECTION 6: MEDICAL PROVIDER SECTION

*****TO BE FILLED OUT BY THE MEDICAL PROVIDER*****

Name of Medical Facility:	
Address:	Phone #:
Name of Doctor (first/last):	Service NPI:
Type of Provider (GP, Cardiologist, Dentist, Etc.):	
Purpose of Visit (**MUST be specific**):	
Is this a Medicaid covered service? ☐ Yes ☐ No	
Is there a referral from the PCP for closest specialty services on file? ☐ YES ☐ NO	
Was the patient hospitalized? ☐ Yes ☐ No	If yes, list admit/discharge dates/times:
Appointment Date:	Appointment Time:

SIGNATURE: _____ **DATE:** _____

(Receptionist, Nurse, or Doctor Signature)

INSTRUCTIONS:

SECTION 1: MEDICAID RECIPIENT INFORMATION
This section contains information regarding the Medicaid recipient or person(s) who had the medical appointment. If additional individuals traveled and had a medical appointment please attach a separate sheet of paper and include the name, date of birth and Medicaid ID number.

SECTION 2: PAYMENT INFORMATION
This section contains the name of the person who reimbursement should be sent to. If assistance was received from another source to help with the medical trip, reimbursement will be sent to the organization first and any remaining balance will be reimbursed to the individual listed in this section.

SECTION 3: FINANCIAL ASSISTANCE
If you checked "YES", you must complete this section. If you received assistance from multiple organizations, please attach a separate sheet of paper and include the organizations name, address, phone number, type of assistance and amount of assistance provided.

SECTION 4: TRIP INFORMATION
This section must be completed by the recipient, parent or guardian. A separate Title XIX Medical Transportation form must be completed for each medical trip.

- From (City) - city from which you departed
- To (City) - city you are traveling to
- Departure Date - date you left your city of residence
- Return Date - date you returned to your city of residence
- Mode of Transportation: how you were transported to your medical appointment
- Lodging: lodging information for the recipient and escort (if medically necessary)

*Motel receipts are required. The receipt must display the nightly rate and verification of payment.
*Fuel and meal receipts are not required.

SECTION 5: SIGNATURE
The form must be signed and dated by the recipient, parent or guardian.

SECTION 6: MEDICAL PROVIDER SECTION
This section MUST be completed and signed by the medical provider. If the recipient has multiple appointments with different doctors, please attach appointment verification and a purpose of visit for each appointment from the medical facility.

MAIL/FAX:
Please make sure that all sections of this form are complete before returning to our office. Incomplete forms may delay the processing of your claim. Please return this form, along with any necessary documentation, referrals 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

PROGRAM GUIDELINES:

- You must be on a medical assistance program that provides Title XIX (Medicaid) coverage at the time of service.
- Transportation must be to the closest medical facility or medical provider capable of providing the necessary services.
- The service must be a Medicaid covered service provided by a medical provider who is enrolled in the medical assistance program.
- Travel to a medical specialist other than a primary care provider requires a referral card. (This does not apply for children in the custody of Child Protection Services.)
- A Title XIX Medical Transportation Reimbursement Form must be completed and submitted for each medical trip.
- Mileage will be reimbursed according to established program guidelines.
- Mileage is limited to the actual miles between two cities and does not include miles driven within the city.
- Lodging is reimbursable when the provider is at least 150 miles from the recipient's city of residence and travel is to obtain specialty care or treatment that results in an overnight stay.
- Meals will be reimbursed only if an overnight stay is medically necessary and the overnight meets the lodging requirement criteria.
- Recipient only: During an inpatient hospital stay meals and lodging will not be reimbursed.
- The Non-Emergency Medical Transportation program must receive a completed claim form within six months following the month the service was provided.
- The Department of Social Services reserves the right to deny coverage for any requests made outside the general coverage guidelines of these rules.