DSS-NEMT-970 01/2024

| *For NEMT Staff use only* |
|---|
| Claim # |

# SOUTH DAKOTA MEDICAID
# NON-EMERGENCY MEDICAL TRAVEL (NEMT) REIMBURSEMENT FORM
# DAY 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 appointment verifications 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 Date: | Appointment Time: | Admission Date: | Time: |
| Was this appointment at an outreach clinic? ☐ Yes ☐ No | | Discharge Date: | Time: |
| Medical Facility Name: | | Billing NPI: | Service NPI: |
| Address: | | | |
| Doctor's Name: | | Phone Number: | Ext: |
| 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 | | | |

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

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

**TRIP INFORMATION** 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: | |
| **If more than one recipient traveled and had a medical appointment, please list them in the following spaces* | |
| Recipient Name: | Phone Number: |
| Medicaid Number: | Date of Birth (mm/dd/yyyy): |
| Recipient Mailing Address: | |
| Recipient Name: | Phone Number: |
| Medicaid Number: | Date of Birth (mm/dd/yyyy): |
| Recipient Mailing Address: | |

**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). (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 the 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_____ | |

*Continued to the next page*

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

**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

| Name of Organization: | Phone #: |
|---|---|
| Mailing Address: | |
| Type of Assistance: ☐ Cash ☐ Meals ☐ 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:
***(Your claim cannot be submitted or processed without a valid NEMT Provider Number)***

| Provider First Name: | Provider Last Name: |
|---|---|
| Provider Mailing Address: | |

| Provider City: | Provider State: | Provider Zip: |
|---|---|---|

**FINAL SUBMISSION** Please submit your appointment verification(s) with this form. An 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.

PRINTED NAME: _____
(Recipient, Parent, or Guardian)

SIGNATURE: _____ DATE: _____
(Recipient, Parent, or Guardian)

## RETURN THIS FORM ALONG WITH ANY NECESSARY DOCUMENTATION OR RECEIPTS BY USING ONE OF THE FOLLOWING SUBMISSION METHODS:

- NEMT Online Portal: https://dss.sd.gov/nemt
- Email: dss.ebtstateoffice@state.sd.us
- Fax: (605) 773-8461
- Mail to: Department of Social Services
  Finance/EBT
  700 Governors Drive
  Pierre, SD 57501

## QUESTIONS?

Please contact our office by calling our toll-free number at 1-866-403-1433 or by sending an email to dss.ebtstateoffice@state.sd.us.