

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 Date:	Appointment Time:	Admission Date:	Time:
Was this appointment at an outreach clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Discharge Date:	Time:	
Medical Facility Name:	Billing NPI:	Service NPI:	
Address:			
Doctor's Name:	Phone Number:	Ext:	
Purpose of Visit:	Medicaid Covered Service: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have a referral on file from the recipient's PCP/HHP provider? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If travel was out of state, is there an Out of State Prior Authorization in place for the dates above? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a continuation for an ongoing trip? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does this trip include stops in more than one city? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Air/Ground Ambulance <input type="checkbox"/> Bus <input type="checkbox"/> IHS Van <input type="checkbox"/> Personal Vehicle <input type="checkbox"/> Shriner's Van <input type="checkbox"/> Transit Provider <input type="checkbox"/> Other _____	

Return Information

Starting Location (City, State):	Ending Location (City, State):
Mode of Travel: <input type="checkbox"/> Air/Ground Ambulance <input type="checkbox"/> Bus <input type="checkbox"/> IHS Van <input type="checkbox"/> Personal Vehicle <input type="checkbox"/> Shriner's Van <input type="checkbox"/> Transit Provider <input type="checkbox"/> Other _____	
Do you have miscellaneous expenses to report? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, Expense Type: <input type="checkbox"/> Public Transportation <input type="checkbox"/> Parking Fees <input type="checkbox"/> Luggage Fees <input type="checkbox"/> 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?	
<input type="checkbox"/> Hotel (receipt required) <input type="checkbox"/> Friend/Family City: _____ State: _____ <input type="checkbox"/> Inpatient Hospital Stay <input type="checkbox"/> Non-Profit <input type="checkbox"/> Other _____ <input type="checkbox"/> Can't remember	<input type="checkbox"/> Hotel (receipt required) <input type="checkbox"/> Friend/Family City: _____ State: _____ <input type="checkbox"/> Inpatient Hospital Stay <input type="checkbox"/> Non-Profit <input type="checkbox"/> Other: _____ <input type="checkbox"/> Home City: _____ State: _____ Mode of Travel: _____ <input type="checkbox"/> Can't remember <input type="checkbox"/> No Escort	

		Did the Escort Travel home and bank the same day? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the mode of travel? _____	
Date (mm/dd/yyyy):			
Where did Recipient stay?		Where did Escort stay?	
<input type="checkbox"/> Hotel (receipt required) <input type="checkbox"/> Friend/Family City: _____ State: _____ <input type="checkbox"/> Inpatient Hospital Stay <input type="checkbox"/> Non-Profit <input type="checkbox"/> Other _____ <input type="checkbox"/> Can't remember		<input type="checkbox"/> Hotel (receipt required) <input type="checkbox"/> Friend/Family City: _____ State: _____ <input type="checkbox"/> Inpatient Hospital Stay <input type="checkbox"/> Non-Profit <input type="checkbox"/> Other: _____ <input type="checkbox"/> Home City: _____ State: _____ Mode of Travel: _____ <input type="checkbox"/> Can't remember <input type="checkbox"/> No Escort	
		Did the Escort Travel home and bank the same day? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the mode of travel? _____	
Date (mm/dd/yyyy):			
Where did Recipient stay?		Where did Escort stay?	
<input type="checkbox"/> Hotel (receipt required) <input type="checkbox"/> Friend/Family City: _____ State: _____ <input type="checkbox"/> Inpatient Hospital Stay <input type="checkbox"/> Non-Profit <input type="checkbox"/> Other _____ <input type="checkbox"/> Can't remember		<input type="checkbox"/> Hotel (receipt required) <input type="checkbox"/> Friend/Family City: _____ State: _____ <input type="checkbox"/> Inpatient Hospital Stay <input type="checkbox"/> Non-Profit <input type="checkbox"/> Other: _____ <input type="checkbox"/> Home City: _____ State: _____ Mode of Travel: _____ <input type="checkbox"/> Can't remember <input type="checkbox"/> No Escort	
		Did the Escort Travel home and bank the same day? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>*Examples include (but are not limited to): Check/Cash, Gas Vouchers, Meal Passes, Lodging Assistance</small>			
Name of Organization:		Phone #:	
Mailing Address:			
Type of Assistance: <input type="checkbox"/> Cash <input type="checkbox"/> Meals <input type="checkbox"/> Lodging <input type="checkbox"/> Transported Recipient <input type="checkbox"/> 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: <i>(Your claim cannot be submitted or processed without a valid NEMT Provider Number)</i>			
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.			
PRINTED NAME: _____ (Recipient, Parent, or Guardian)			
SIGNATURE: _____ (Recipient, Parent, or Guardian)		DATE: _____	

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

Department of Social Services

Local Phone Number: (605) 773-6527

Finance/EBT

Toll Free Number: 866-403-1433

700 Governor's Drive

Fax Number: (605) 773-8461

Pierre, SD 57501

Email: dss.ebtstateoffice@state.sd.us

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