SOUTH DAKOTA MEDICAID
TRANSPORTATION DOCUMENTATION FORM

Community transportation and secure medical transportation providers may keep this form on file to support that the recipient was transported to a medical appointment. Secure medical transportation providers may also use the form to support that the recipient was confined to a wheelchair or required transportation on a stretcher. Documentation may be requested as part of post payment claim review.

SECTION 1: MEDICAID RECIPIENT INFORMATION
Recipient Name:
Medicaid ID Number:
SECTION 2: TRIP INFORMATION
Type of Transportation: ☐ Community Transportation ☐ Secure Medical Transportation
Driver's Name:
Date of Trip:
Medical Facility:
Medical Practitioner's Name:
SECTION 3: SECURE MEDICAL TRANSPORTATION ONLY
Secure Medical Transportation may only be provided to a recipient confined to a wheelchair or a recipient who requires transportation on a stretcher. Confined to a wheelchair means unable to walk without the continuous aid of another person or unable to walk in any circumstances. Being discharged from a hospital in a wheelchair does not necessarily mean the recipient is confined to a wheelchair. The recipient is confined to a wheelchair or requires transportation on a stretcher: ☐ Yes ☐ No
SECTION 4: SIGNATURES
I understand that South Dakota Medicaid only pays for community transportation/secure medical transportation from a recipient's home to a medical provider for diagnosis or treatment, between medical providers when necessary, or from a medical provider to the recipient's home. I attest that the information on this form is true and complete to the best of my knowledge. **SIGNATURE:**_____**DATE:** _____ (Recipient, Parent, or Guardian) **SIGNATURE:**_____**DATE:** _____ (Driver) **SIGNATURE:**_____**DATE:** _____ (Receptionist, Nurse, or Doctor)