DSS-NEMT-973 12/23

For NEMT Staff use only
Claim #

SOUTH DAKOTA MEDICAID NON-EMERGENCY MEDICAL TRAVEL APPOINTMENT VERIFICATION FORM

Complete one section per appointment

Recipient Name:	Medicaid Number:

*****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? ☐ Yes ☐ No		Discharge Date:	Time:
Medical Facility Name:		Billing NPI:	Servicing 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)

Recipient Name:	Recipient ID #:

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