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)