

TITLE XIX MEDICAL TRANSPORTATION REIMBURSEMENT FORM

MULTIPLE TRIPS TO THE SAME PROVIDER

Medicaid Recipient's Name _____	Date of Birth _____	Medicaid # _____
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Payment Goes To _____

Mailing Address _____

Phone # _____

Have you received any financial assistance from another source to help with these trips? YES NO
 If yes, who? _____ Amount: \$ _____

APPOINTMENT DATE AND TIME	FROM (City)	TO (City)	DEPARTUR E DATE/TIME	RETURN DATE/TIME	LODGING - IF OVERNIGHT (Circle One)
					Motel - Family/Friends - Hospital - Other
					Motel - Family/Friends - Hospital - Other
					Motel - Family/Friends - Hospital - Other
					Motel - Family/Friends - Hospital - Other
					Motel - Family/Friends - Hospital - Other
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					Motel - Family/Friends - Hospital - Other
					Motel - Family/Friends - Hospital - Other

TO BE FILLED OUT BY THE MEDICAL PROVIDER

Name of Medical Facility: _____

Address: _____ Phone Number: _____

Name of Doctor: _____ Service NPI #: _____

Type of Provider (GP, Cardiologist, Dentist, etc.): _____

Purpose of Visits (be specific): _____

Is this a Medicaid covered service? Yes No

Is a referral from the PCP for closest specialty services on file? Yes No Not Required

Was the patient hospitalized? Yes No If yes, please list admit/discharge dates _____

Signature: _____ **Date:** _____

(Receptionist, Nurse, or Doctor Signature)

- Mileage will be reimbursed according to established program guidelines.
- Mileage is limited to the actual miles between two cities and does not include miles driven within the city.
- Travel to a medical specialist other than a primary care provider requires a referral card.
(This does not apply for children in the custody of Child Protection Services.)
- Lodging is reimbursable when the provider is at least 100 miles from the recipient's city of residence and travel is to obtain specialty care or treatment that results in an overnight stay. A motel receipt is required for lodging reimbursement.
- Meals will be reimbursed only if an overnight stay is medically necessary and the overnight meets the lodging requirement criteria.
- Recipient only: During an inpatient hospital stay meals and lodging will not be reimbursed.

I understand that I will be paid mileage only to the closest provider capable of providing the necessary services. I certify that the above information is correct to the best of my knowledge and the attached receipts, if any, represent eligible expenses.

SIGNATURE _____ **Date** _____
 (Recipient, parent, or guardian)

Please return this form, along with any necessary referrals or receipts, to: Dept. of Social Services
 Local Phone Number: (605) 773-6527 Finance/EBT
 Toll Free Number: 866-403-1433 700 Governors Drive
 Fax Number: (605) 773-8461 Pierre, SD 57501

NOTE: There are penalties for fraudulently submitting claims for reimbursement and misrepresentation of receipts submitted for payment.