DSS-OS-957 01/10

TITLE XIX MEDICAL TRANSPORTATION REIMBURSEMENT FORM

** MULTIPLE TRIPS TO THE SAME PROVIDER**

Medicaid Recipient's Name	Date of Birth	Medicaid #

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)	DEPARTURE 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
						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

*** 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:

Local Phone Number: (605) 773-6527
Toll Free Number: 866-403-1433
Fax Number: (605) 773-8461

Dept. of Social Services
Finance/EBT
700 Governors Drive
Pierre, SD 57501

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