MEDICAID TRANSPORTATION EXCEPTION VERIFICATION

Section 1 – Identifying Information (DSS completes)

_____ County Department of Social Services Date _____

Beneficiary Name _____ Address _____

Date of Birth _____ Medicaid ID_____

Phone _____

Caseworker Name _____ Caseworker Phone _____

Section 2 – Medicaid Beneficiary Consent to Release Information

I, _____, have requested Medicaid transportation assistance.

I authorize _____ to release information requested below to the Department of Social Services. (doctor, clinic, other medical provider name)

This authorization is valid for up to one year from the date signed. I understand that I may revoke this authorization at any time by submitting a written request to the County DSS. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____
Medicaid beneficiary's or representative's signature Date

Note to Beneficiary: bring this form to your provider to complete and have your provider fax it to DSS at _____. Forms returned directly to DSS by the beneficiary will not be considered.

Section 3 – Exception Requested and Justification **Return Date** _____

Medicaid regulations limit transportation to the closest appropriate provider by the most economical means available. You only need to complete this form if an exception is required.

The Medicaid beneficiary named above has requested:

Transportation to a provider located at a significantly greater distance
A special mode of transportation (attendant, service animal, vehicle type, etc.)
Lodging

Duration of Need: From _____ to _____ or Permanent _____

If the beneficiary is requesting transport to a provider located at a significantly greater distance:
Please provide the name, address and phone number of the medical provider to whom the beneficiary is being referred:

Name _____ Phone _____
Address_____

Please explain why this beneficiary cannot be served by a provider within the normal service area.

_____
_____

Section 3 – Exception Requested and Justification

If the beneficiary has requested a special mode of transportation or has a special need, please explain:

Indicate the special mode or need? (attendant, service animal, vehicle type, other) _____
Why is this accommodation necessary?

_____

_____

If the beneficiary will need lodging during his/her treatment, please explain why the beneficiary will have to stay overnight near the treatment facility (to be completed by provider at facility).

_____

_____

For how long (number of nights) will the beneficiary need to remain near the facility?

From _____ To _____

Section 4 – Attestation

To the best of my knowledge, the above statements are true and correct.

Name of provider completing form (print): _____ Phone _____

Provider's Signature: _____ Date _____

Incomplete or inaccurate forms will not be approved, and could delay transportation to medical service