# Medicaid Transportation Monitoring Report

_________________County DSS

Recipient Name__________________________________________________________

Medicaid ID Number__________________Date of Transport____________________

Vendor Used____________________________________________________________

Medical Provider Name___________________________________________________

Medical Provider Telephone Number________________________________________

## Please circle one answer for each question below.

Was recipient authorized for Medicaid on trip date? **Yes** or **No**

Was recipient in an eligible Medicaid category? **Yes** or **No**

Was recipient transported to a Medicaid Enrolled Provider? **Yes** or **No**

Did recipient receive a Medicaid covered service? **Yes** or **No**

DHB-5048, Transportation Exception Verification Form in the file? **Yes** or **No** or **N/A** Current

DHB-5046, Notice of Rights in the file? **Yes** or **No**

Current DHB-5047, Medicaid Assessment in the file? **Yes** or **No**

Current DHB-5024, Transportation Assessment Notification in the file? **Yes** or **No**

Calculation of the reimbursement for the trip/related expenses done correctly? **Yes** or **No**

Was there a DHB-5019, Denial of Transportation Request provided to the recipient? **Yes** or **No** or **N/A**

Trip coded correctly for reimbursement on the DHB-2056, Transportation Log? **Yes** or **No**

**Review Date**_____________________________________________________________

**Name of Monitor**__________________________________________________________

DHB-5078
03/2022