MEDICAID TRANSPORTATION
VERIFICATION OF RECEIPT OF MEDICAID COVERED SERVICE

TO: Medicaid Enrolled Provider

From: _____ County Department of Social Services

Note: The County has the authority to administer the Medicaid program for the North Carolina Department of Health and Human Services Division of Medical Assistance pursuant to N.C.G.S. 108A-25 and rules adopted by the State of North Carolina.

When transportation assistance is provided to a Medicaid recipient, for audit purposes, it is necessary for the county to document that the individual received a Medicaid covered service from a Medicaid-enrolled provider on the date of transport. Please complete the following:

This is to certify that _____
(Medicaid recipient's name/Medicaid ID Number)

visited this office or facility on _____ and received a Medicaid covered service.
(date)

Name of Medicaid provider/facility: _____

Name/Title of individual completing form (please print) _____

_____

Phone number of person completing form _____

Signature of person completing form: _____

Medicaid Beneficiary Consent to Release Information

I, _____, have requested Medicaid transportation assistance.

I authorize _____ to release information requested above to the (doctor, clinic, other medical provider name)

Department of Social Services listed on this form.

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 I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.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