

# TITLE XIX MEDICAL TRANSPORTATION REIMBURSEMENT FORM

-To Be Returned After Your Trip -

Medicaid Recipient's Name

Date of Birth

Medicaid #

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(If there are additional family members that traveled and had a medical appointment, please list them on back of the sheet)

Recipient Address \_\_\_\_\_

Phone # \_\_\_\_\_

Payment Goes To \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

Appointment Date \_\_\_\_\_ Appointment Time \_\_\_\_\_

City of origin \_\_\_\_\_ Destination (city) \_\_\_\_\_

Departure Date \_\_\_\_\_ Time \_\_\_\_\_ Return Date \_\_\_\_\_ Time \_\_\_\_\_

**Lodging:** Please list specific days/times on the reverse for both the recipient and escort for accurate reimbursement.

Recipient:  Motel (receipt required)  Family/Friend (no receipt required)  Stayed at Hospital (no receipt required)

Driver/Escort:  Motel (receipt required)  Family/Friend (no receipt required)  Stayed at Hospital (no receipt required)

Have you received any assistance from another source to help with this trip?  YES  NO

If yes, who? \_\_\_\_\_ Amount: \$ \_\_\_\_\_

**\*To be filled out by the Medical Provider\***

Name of Medical Facility: \_\_\_\_\_

Address and Phone Number: \_\_\_\_\_

Name of Doctor: \_\_\_\_\_

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

Purpose of visit: \_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Receptionist, Nurse, or Doctor Signature)

- Mileage will be reimbursed according to established program guidelines.
- Travel to your primary care physician will **not** be reimbursed
- Travel to a physician within your city limits will **not** be reimbursed.
- A motel receipt is required for lodging reimbursement for a driver and/or the recipient (maximum of 2).
- Meals will be reimbursed only if the medical appointment requires an overnight stay.

- 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	Fax Number: (605) 773-8461
Finance/EBT	Toll Free Number: 866-403-1433
700 Governors Drive	Local Phone Number: (605) 773-6527
Pierre SD 57501	

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