SOUTH DAKOTA MEDICAID
TRANSPORTATION DOCUMENTATION FORM

Community transportation and secure medical transportation providers may keep this form on file to support that the recipient was transported to a medical appointment. Secure medical transportation providers may also use the form to support that the recipient was confined to a wheelchair or required transportation on a stretcher. Documentation may be requested as part of post payment claim review.

SECTION 1: MEDICAID RECIPIENT INFORMATION

Recipient Name:

Medicaid ID Number:

SECTION 2: TRIP INFORMATION

Type of Transportation: ☐ Community Transportation ☐ Secure Medical Transportation

Driver's Name:

Date of Trip:

Medical Facility:

Medical Practitioner's Name:

SECTION 3: PHARMACY, DURABLE MEDICAL EQUIPMENT, AND OPTICAL SUPPLY ONLY

Reason for Transportation:

☐ No delivery available

☐ First fill of a new prescription

☐ Equipment fitting/adjustment

SECTION 4: SECURE MEDICAL TRANSPORTATION ONLY

Secure Medical Transportation may only be provided to a recipient confined to a wheelchair or a recipient who requires transportation on a stretcher. Confined to a wheelchair means unable to walk without the continuous aid of another person or unable to walk in any circumstances. Being discharged from a hospital in a wheelchair does not necessarily mean the recipient is confined to a wheelchair.

The recipient is confined to a wheelchair or requires transportation on a stretcher: ☐ Yes ☐ No

SECTION 5: SIGNATURES

I understand that South Dakota Medicaid only pays for community transportation/secure medical transportation from a recipient's home to a medical provider for medically necessary services, between medical providers when necessary, or from a medical provider to the recipient's home. I attest that the information on this form is true and complete to the best of my knowledge.

SIGNATURE:______________________________ **DATE:** ____________

(Recipient, Parent, or Guardian)

SIGNATURE:______________________________ **DATE:** ____________

(Driver)

SIGNATURE:______________________________ **DATE:** ____________

(Receptionist, Nurse, Doctor, or Pharmacy Staff)