HEALTH CARE AUTHORITY

MEDICAID TRANSPORTATION VERIFICATION FORM-295

(Must be completed for each new transport)

This form must be retained in the provider's file

Section 1 – CLIENT DECLARATION

Recipient Name:	Recipient ID:	Birth Date
Address – *No. & Street/PO Box/ Rural Route/Apt. No*.		
City	State	Zip Code

❑ I do not have a vehicle and I do not have anyone to transport me to my medical service provider.

❑ I do not have access to other transportation such as bus service.

I solemnly swear that the information I have given is true and accurate. I understand that any false information I provide may result in the termination of my medical coverage and imposition of other civil and criminal actions as appropriate.

Recipient Signature _____	Date

Section 2 – MEDICAL PROVIDER

This is to certify that _____
(Name of Client)

Medicaid client number _____ was transported on _____
(Date)

from _____ to _____
(Street Address, City State) *(Street Address, City State)*

TRANSPORTATION FOR (Check applicable box) ❑ Medical Treatment ❑ Other (Specify) _____

Printed Name of Physician _____

Signature of Physician/Medical Practitioner/Office Staff	Date of Signature	Provider Number

Section 3 – TRANSPORTATION PROVIDER

As transportation provider for the above named Medicaid client, we confirm that we are familiar with all Medicaid transportation regulations and policy requirements and they have been met.

Mileage To: **Mileage From:**	**Medical Attendant** ❑ Yes ❑ No	**Total Amount Due:**
Company Name:		Telephone Number ( )

ADDRESS – No. & Street	City	State	Zip Code
Signature of Driver_____		Date of Signature	

I understand that any false information I provide may result in the termination of my Medicaid Provider agreement, and imposition of other civil and/or criminal actions as appropriate.

HEALTH CARE AUTHORITY

MEDICAID TRANSPORTATION ATTESTATION FORM -296

This form must be submitted with the HCPA-1500 claim form and a copy retained in the provider's file.

Section A – NEED FOR MEDICAL ATTENDANT DECLARATION

Recipient Name:	Recipient ID:	Birth Date

Address – *No. & Street/PO Box/ Rural Route/Apt. No*.

City State Zip Code

Can the recipient be transported safely without an attendant? ❑ Yes ❑ No

Why is a transportation attendant needed? _____

If not permanent, what is the expected duration of impairment necessitating attendant? _____

Primary Provider Signature	Date of Signature	Medicaid Provider

❑ Attestation obtained by phone from the medical provider or office nurse.	Printed Name of Primary Physician	Provider Number	Provider Telephone Number
	I understand that any false information I provide may result in the termination of my Medicaid Provider Agreement, and imposition of other civil and/or criminal actions as appropriate.		

***Note - Medical justification for a medical attendant must be noted in and retained as part of the recipient's medical record.**

Section B – OUT- OF- COMMUNITY TRANSPORTATION ATTESTATION

This client requires medical/diagnostic service which is unavailable in this area and his/her medical condition requires transportation by: ❑ Commercial Bus ❑ Taxicab/Handivan ❑ Ambulance ❑ Commercial Air

Medical/Diagnostic Service	Anticipated period required for out-of- community care: _____ _____ *(For continued out-of- community non- emergency transportation, the required information must be obtained every six (6) months, regardless of the frequency of transport)*

Referral is being made to:

ADDRESS – *No. & Street* *City* *State* *Zip Code*

Referring Medical Provider's Signature	Date of Signature	Medicaid Provider Number

❑ Attestation obtained by phone from the medical provider or office nurse.	Printed Name of Primary Physician	Provider Number	Provider Telephone Number
	I understand that any false information I provide may result in the termination of my Medicaid Provider Agreement, and imposition of other civil and/or criminal actions as appropriate.		

Section C – TRANSPORTATION PROVIDER

As the transportation provider for the above named Medicaid client, we confirm, that we are familiar with all Medicaid transportation regulations and policy requirements and they have been met.

Signature of Driver	Date

Transportation Company Name	Provider Number

ADDRESS – *No. & Street* *City* *State* *Zip Code*

Company Owner's Signature	**I understand that any false information I provide may result in the termination of my Medicaid Provider Agreement, and imposition of other civil and/or criminal actions as appropriate.**