# 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:**<br>**Mileage From:** | **Medical Attendant**<br>❑ Yes ❑ No | | **Total Amount Due:** |
|---|---|---|---|
| Company Name: | | | Telephone Number<br>( ) |
| 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: ____________________<br>*(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.** |
|---|---|