

MEDICAID TRANSPORTATION MEDICAL NECESSITY VERIFICATION

Section 1 – Department of Social Services Completes:

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|---------------------------------|---|------------------|
| Patient/Medicaid Recipient Name | Address | Phone Number |
| Medicaid Recipient ID Number | County Case # District # | Program/Category |
| _____ Dept. of Social Services | Caseworker Name | Phone Number |

Section 2 – Medicaid Recipient Completes:

I, _____, have requested Medicaid transportation assistance which requires medical necessity authorization. I authorize (Print name of doctor, clinic, etc.) _____ to release the information requested below to the _____ County Department of Social Services.

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 I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

_____/_____
Medicaid Recipient or Representative's Signature Relationship to Recipient Signature Date

Section 3 – Medical Provider Completes:

At the request of the Medicaid recipient, we would appreciate your cooperation in completing the information in Section 3 below.

| | | | |
|--|---|--|--|
| Medical Provider's Name | Title | Phone Number | Address |
| Does someone need to accompany the patient to the medical appointment? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, who : | If Yes, medical reason for accompaniment : | Is special transportation needed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Type (Van with wheelchair lift, etc.): | If Yes, medical reason for special transportation : |
| Date of last medical visit: | Period of time medically necessary attendant and special transportation needed: _____ thru _____ | Is overnight stay required? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, where : | If Yes, medical reason for overnight stay : |

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|---|---|
| _____ Physician Signature Signature Date | DMA-5048 (11/06) Authority: Federal 45 CFR 431.53 & G.S. 108-A-14(3) & (5) Completion: Voluntary Penalty: Medicaid transportation assistance may be affected. |
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