

Medicaid Transportation Monitoring Report

_____ County DSS

Recipient Name _____

Medicaid ID Number _____ Date of Transport _____

Vendor Used _____

Medical Provider Name _____

Medical Provider Telephone Number _____

Please circle one answer for each question below.

Was recipient authorized for Medicaid on trip date? **Yes** or **No**

Was recipient in an eligible Medicaid category? **Yes** or **No**

Was recipient transported to a Medicaid Enrolled Provider? **Yes** or **No**

Did recipient receive a Medicaid covered service? **Yes** or **No**

DMA-5048, Transportation Exception Verification Form in the file? **Yes** or **No** or **N/A**

Current DMA-5046, Notice of Rights in the file? **Yes** or **No**

Current DMA-5047, Medicaid Assessment in the file? **Yes** or **No**

Current DMA-5024, Transportation Assessment Notification in the file? **Yes** or **No**

Calculation of the reimbursement for the trip/related expenses done correctly? **Yes** or **No**

Was there a DMA-5019, Denial of Transportation Request provided to the recipient? **Yes** or **No** or **N/A**

Trip coded correctly for reimbursement on the DMA-2056, Transportation Log? **Yes** or **No**

Review Date _____

Name of Monitor _____