

# MEDICAID TRANSPORTATION MEDICAL NECESSITY VERIFICATION

## Section 1 – Department of Social Services Completes:

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 I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.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, <b>medical reason for accompaniment:</b>	Is special transportation needed? <input type="checkbox"/> Yes <input type="checkbox"/> No  If Yes, <b>Type</b> (Van with wheelchair lift, etc.):	If Yes, <b>medical reason for special transportation:</b>
Date of <b>last</b> 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, <b>where:</b>	If Yes, <b>medical reason for overnight stay:</b>
_____ <b>Physician Signature</b>		_____ <b>Signature Date</b>	

**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.

Figure 12