MEDICAID TRANSPORTATION EXCEPTION VERIFICATION

Section 1 – Identifying Information (DSS completes)

_____ County Department of Social Services Date _____

Recipient Name _____ Address _____

Phone _____ Medicaid ID _____

Caseworker Name _____ Caseworker Phone _____

Section 2 – Medicaid Recipient Consent to Release Information

I, _____, have requested Medicaid transportation assistance.

I authorize _____ to release information requested below to the
(doctor, clinic, other medical provider name)
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 DSS. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

_____ ___ _____
Medicaid recipient's or representative's signature Date

Section 3 – Medical Provider Certification

The Medicaid recipient named above has requested:

- ☐ Transportation to a provider located outside of the normal transport area
- ☐ A special mode of transportation

We need your assistance in determining the necessity for the request. Please answer the following questions.

If the recipient is requesting transport outside of the community:
Please provide the name, address and phone number of the medical provider to whom the recipient is being referred (if applicable) _____
Phone _____ Address _____

Have efforts been made to find a closer provider? ☐ Yes ☐ No ☐ N/A
Is it medically necessary for this provider to treat this patient? ☐ Yes ☐ No ☐ N/A

If the recipient has requested a special mode of transportation:
Are there special transportation needs that you are aware of? ☐ Yes ☐ No ☐ N/A
Please explain: _____

Name of Physician completing form: _____ Phone _____

Duration of need: From _____ To _____ OR ☐ Permanent

Physician's Signature: _____ Date _____