MEDICAID TRANSPORTATION
VERIFICATION OF RECEIPT OF MEDICAID COVERED SERVICE

TO: Medicaid Enrolled Provider

From: ____________________________ County Department of Social Services

When transportation assistance is provided to a Medicaid recipient, for audit purposes, it is necessary to document that the individual received a Medicaid covered service from a Medicaid-enrolled provider on the date of transport. Please complete the following:

This is to certify that ___________________________________ visited this office or facility on
(Medicaid recipient's name/Medicaid ID Number)

__________________________ and received a Medicaid covered service.
(date)

Name of Medicaid provider/facility: ____

Signature of person completing form on behalf of provider: _____________________________

DMA-5118
1/1/2012

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