Michigan Department of Community Health

MEDICAL TRANSPORTATION STATEMENT

- Only **ONE** medical provider and **ONE** transporter per form.
- See **Page 2** for Instructions, Copy Distribution, PA 431 and Non-Discrimination Information.

Document Number

SECTION I - DHS Specialist Completes:

DHS Specialist Name							Authorized Rate Standard ☐ Special ☐	DHS Specialist Phone No. ( )	Level of Care Code
Patient/ Beneficiary Name							Beneficiary ID No.	Patient/ Beneficiary Street Address	Patient/Bene. Phone # ( )
DHS Case No.	Prog. Code	CO #	DIST #	SEC	UNIT	DHS SPEC	City	State	ZIP Code

SECTION II - Medical Provider Completes:

Medical Provider's Name (MD, DO, DDS)	NPI Number	Address (No., Street, Bldg., Suite, etc.)	Provider's Phone No. ( )
Diagnosis(es)		City / State	ZIP Code
Chronic, ongoing illness? (This usually means monthly ongoing care, but may include less than monthly care.) ☐ YES ☐ NO	Is overnight stay required? ☐ YES ☐ NO	Was patient referred to you? ☐ YES → ☐ NO	Name of Referring Physician
Does someone need to accompany the patient to the medical appointment? ☐ YES → ☐ NO	If YES, Who & Why	Is special transportation needed? ☐ YES → ☐ NO	Type (Van w/ wheelchair lift, etc.)

SECTION III - Transportation Provider Completes:

Transportation Provider's Name (Last, First)	Soc. Sec. No. or ID No.	Type of Transportation	Other Expenses (Parking Receipts, etc.)
Transportation Provider's Complete Address (No. & Street, City, State, ZIP Code)			Phone No. ( )

SECTION IV - Transportation Record (Provider / Transporter / Beneficiary Sign for EACH Visit):

Appointment Date	Depart. Time	Return Time	Round Trip Miles	Other Expenses	Beneficiary's Signature	Transporter's Signature	Medical Provider's Signature
TOTALS				$	I certify that I received Medical Transportation service on the date(s) above.	I certify that I provided Medical Transportation service on the date(s) above.	I certify that I am a Medicaid enrolled provider and that I provided a medical service on the appointment date(s) above.

SECTION V - Local DHS Specialist & Manager Complete:

A) Total Number of Miles **X** Appropriate rate in the BAM 825.	$	D) Greater of Line A or $1.80	$	DHS Specialist's Signature	Date
B) Special Rate (DHS-54A Received)	$	E) Other Expenses	$	DHS Manager's Signature	Date
C) Total of Lines A + B	$	F) Total Authorized: Special Rate = C + E All Other = D + E	$		

SECTION VI - Local DHS Accounting Use Only:

Audited and Approved by: Date			Doc. Type	Intf. Type	PDT	Bank ID No.	DMI
Appr. Yr.	Index	PCA	Agency Object Code			Amount $	
NIGP Code	MAIN/LOAAS Doc. No.	Check No. & Date	LOAAS Account No.				

MSA-4674 (03/14) Previous editions are obsolete.

Instructions for MSA-4674

(Medical Transportation Statement)

GENERAL INSTRUCTIONS:

- **Use one form per month for each medical provider or transporter.**
- Use this form for 5 or less trips made in a calendar month.
- This form must be returned to the local Michigan Department of Human Services local office within **90 calendar days** from the date of service to authorize payment for medical transportation.

COMPLETION INSTRUCTIONS:

SECTION I:

- The DHS Specialist completes this section.

SECTION II:

- The medical provider completes this section. (Only one medical provider per form.)
- Diagnosis is not required if a DHS-54A was completed in the past year.

SECTION III:

- The transportation provider completes this section.
- Use only ONE transporter per form.
- Leave this section BLANK if the beneficiary drives themselves OR if the beneficiary wishes to receive the transportation payment directly.

SECTION IV - Transportation Record:

Transporter:

- Enter the following for each appointment/visit: date, departure time, return time, number of miles traveled (round trip) and the attendant fee if medically authorized.
- Sign EACH appointment line. This verifies that transportation services were provided on that date.
- If SECTION III was completed, then only that transporter may sign in this section.

Medical Provider (or their staff):

- Confirm the date(s) of appointment(s) and sign your name to verify that the medical visit did occur.

Patient/Beneficiary:

- Sign each appointment line even if you transported yourself. This is also used to verify that each medical appointment was kept and that transportation services were provided.

SECTION V:

- The DHS Specialist calculates the transportation payment and signs their name and dates.
- The DHS Manager reviews the entire form and signs their name approving the payment.
- The local office must then approve the MSA-4674 and submit it to the appropriate DHS Accounting Service Center within 10 business days of receipt of the form.

SECTION VI:

- The local DHS Accounting Unit completes this section.

COPY DISTRIBUTION:

Original:	• Mail or give this copy to the **Beneficiary** for completion by the Beneficiary, medical provider and the transporter. • **Return to DHS Specialist** for completion. Forward to the local DHS Accounting Unit for payment processing.
Copy 1:	• Local DHS Case File copy
Copy 2:	• Give this copy to the Beneficiary and/or Transporter.

AUTHORITY: COMPLETION:	Title XIX of the Social Security Act Is Voluntary but required if payment from applicable programs is sought.	The Department of Community Health is an equal opportunity employer, services and programs provider.

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