Instructions in the use of Revised MAD-295 – Medicaid Transportation Verification Form & MAD-296 – Medicaid Transportation Attestation Form

Medical Attendant

At no time may a Medicaid provider supply an attendant to accompany a Medicaid client on a non-emergency transport to an appointment, unless the client or primary physician specifically requests one, and the primary care provider verifies medical necessity. The client, medical provider/office staff, and transportation provider must complete Medicaid Transportation Verification Form-295, and medical provider/office staff and transportation provider must complete Sections A and C on the Medicaid Transportation Attestation Form-296, with information provided by the primary physician, indicating that a medical attendant is medically necessary. This information must be on file for reimbursement.

Out-of-Community Transportation

If a client must travel over sixty-five (65) miles from his/her home community to receive medical care, the client, medical provider/office staff, transportation provider must complete Medicaid Transportation Verification Form-295, and the medical provider/office staff and transportation provider must complete Sections B and C on the Medicaid Transportation Attestation Form-296 with information provided by the primary physician, indicating the medical and/or diagnostic service the client is being referred for; the name of the out-of-community medical provider; and the justification that the medical care is not available in the home community.

Specific Instructions

1. Medicaid Transportation Verification Form – 295 is to be used on ALL Medicaid client transports – one-way without return, or roundtrip transportation. This form must also be completed when a client is in a facility, and requires family members to travel to the facility as a part of the treatment plan. All Sections must be completely filled out for each new transport.

IN ADDITION TO MAD-295:

2. If a medical attendant is required, Medicaid Transportation Attestation Form-296 – Sections A and C must also be completely filled out.
3. If a client requires out-of-community transportation, Medicaid Transportation Attestation Form-296 – Sections B and C must also be completely filled out.
4. If a client requires out-of-community transportation and a medical attendant, Medicaid Transportation Attestation Form-296 – Sections A, B, and C must also be completely filled out.

Policy procedures apply regarding record retention for this document (five year retention). Failure to have the forms completed and on file, before providing transportation, may result in recoupment of payment or other actions.

MEDICAID TRANSPORTATION VERIFICATION FORM - 295

(Must be completed for each new transport)

MEDICAL ASSISTANCE DIVISION

This form must be retained in the provider's file

Section 1 - CLIENT DECLARATION

Recipient Name	Recipient I. D.	Birth Date

ADDRESS - *No. & Street/ P.O. Box/ Rural Route/ Apt. No.*

City	State	Zip Code

❑ I do not have a vehicle and I do not have anyone to transport me to my medical service provider.

❑ I do not have access to other transportation such as bus service.

I solemnly swear that the information I have given is true and accurate. I understand that any false information I provide may result in the termination of my Medicaid coverage and imposition of other civil and criminal actions as appropriate.

Recipient Signature	Date

Section 2 - MEDICAL PROVIDER

This is to certify that .... *(Name of Client)*

Medicaid client number ...., was transported on .... *(Date)*

from .... *(Street Address, City, State)* to .... *(Street Address, City, State)*

TRANSPORTATION FOR *(Check applicable box):* ❑ Medical Treatment ❑ Pharmacy ❑ Other *(Specify)*..............

Printed Name of Physician

Signature of Physician/Medical Practitioner/Office Staff	Date of Signature	Provider Number

Section 3 - TRANSPORTATION PROVIDER

As the transportation provider for the above named Medicaid client, we confirm that we are familiar with all Medicaid transportation regulations and policy requirements and they have been met.

Mileage To: **Mileage From:**	**Medical Attendant:** ❑ Y ❑ N	**Total Amount Due:**

Company Name	Telephone Number

ADDRESS - *No. & Street*	*City*	*State*	*Zip Code*

Signature of Driver	Date of Signature

I understand that any false information I provide may result in the termination of my Medicaid Provider Agreement, and imposition of other civil and/or criminal actions as appropriate.

MEDICAL ASSISTANCE DIVISION

MEDICAID TRANSPORTATION ATTESTATION FORM - 296

This form must be submitted with the HCPA-1500 claim form and a copy retained in the provider's file.

Section A - NEED FOR MEDICAL ATTENDANT DECLARATION

Recipient Name	Recipient I. D.	Birth Date

ADDRESS - *No. & Street/ P.O. Box/ Rural Route/ Apt. No.*

City	State	Zip Code

Can the recipient be transported safely without an attendant? ☐ Yes ☐ No

Why is a transportation attendant needed? ____________________

If not permanent, what is the expected duration of impairment necessitating attendant? ____________________

Primary Provider Signature	Date of Signature	Medicaid Provider

☐ Attestation obtained by phone from the medical provider or office nurse.	Printed Name of Primary Physician	Provider Number	Telephone Number
	I understand that any false information I provide may result in the termination of my Medicaid Provider Agreement, and imposition of other civil and/or criminal actions as appropriate.		

***Note - Medical justification for a medical attendant must be noted in and retained as part of the recipient's medical record.**

Section B - OUT-OF-COMMUNITY TRANSPORTATION ATTESTATION

This client requires medical/diagnostic service which is unavailable in this area and his/her medical condition requires transportation by: ☐ Commercial Bus ☐ Taxicab/Handivan ☐ Ambulance ☐ Commercial Air

Medical/Diagnostic Service	Anticipated period required for out-of-community care: ____________________ *(For continued out-of-community non-emergency transportation, the required information must be obtained every six (6) months, regardless of the frequency of transport)*

Referral is being made to:

ADDRESS - *No. & Street*	*City*	*State*	*Zip Code*

Referring Medical Provider's Signature	Date of Signature	Medicaid Provider Number

☐ Attestation obtained by phone from the medical provider or office nurse.	Printed Name of Primary Physician	Provider Number	Telephone Number
	I understand that any false information I provide may result in the termination of my Medicaid Provider Agreement, and imposition of other civil and/or criminal actions as appropriate.		

Section C - TRANSPORTATION PROVIDER

As the transportation provider for the above named Medicaid client, we confirm that we are familiar with all Medicaid transportation regulations and policy requirements and they have been met.

Signature of Driver	Date

Transportation Company Name	Provider Number

ADDRESS - *No. & Street*	*City*	*State*	*Zip Code*

Company Owner's Signature	**I understand that any false information I provide may result in the termination of my Medicaid Provider Agreement, and imposition of other civil and/or criminal actions as appropriate.**

A0429 - Amb. Services, BLS, ER transport - Modifiers identify origin and destination of transport. Refer to Policy 8.324.7 for covered services and service limitations and components included in base rate.	$301.31; 1 unit = 1 base rate	DD, DE, DG, DH, DI, DJ, DN, DP, DR, DX, ED, EE, EG, EH, EI, EJ, EN, EP, ER, EX, GD, GE, GG, GH, GI, GJ, GN, GP, GR, GX, HD, HE, HG, HH, HI, HJ, HN, HP, HR, HX, ID, IE, IG, IH, II, IJ, IN, IP, IR, IX, JD, JE, JG, JH, JI, JJ, JN, JP, JR, JX, ND, NE, NG, NH, NI, NJ, NN, NP, NR, NX, PD, PE, PG, PH, PI, PJ, PN, PP, PR, PX, RD, RE, RG, RH, RI, RJ, RN, RP, RR, RX, SD, SE, SG, SH, SI, SJ, SN, SP, SR, SX
A0380 - BLS Mileage - Modifiers identify origin and destination of transport. Refer to Policy 8.324.7 for covered services and service limitations and components included in base rate.	$3.40; 1 unit = 1 mile	DD, DE, DG, DH, DI, DJ, DN, DP, DR, DX, ED, EE, EG, EH, EI, EJ, EN, EP, ER, EX, GD, GE, GG, GH, GI, GJ, GN, GP, GR, GX, HD, HE, HG, HH, HI, HJ, HN, HP, HR, HX, ID, IE, IG, IH, II, IJ, IN, IP, IR, IX, JD, JE, JG, JH, JI, JJ, JN, JP, JR, JX, ND, NE, NG, NH, NI, NJ, NN, NP, NR, NX, PD, PE, PG, PH, PI, PJ, PN, PP, PR, PX, RD, RE, RG, RH, RI, RJ, RN, RP, RR, RX, SD, SE, SG, SH, SI, SJ, SN, SP, SR, SX
A0390 - ALS Mileage - Modifiers identify origin and destination of transport. Refer to Policy 8.324.7 for covered services and service limitations and components included in base rate.	$3.40; 1 unit = 1 mile	DD, DE, DG, DH, DI, DJ, DN, DP, DR, DX, ED, EE, EG, EH, EI, EJ, EN, EP, ER, EX, GD, GE, GG, GH, GI, GJ, GN, GP, GR, GX, HD, HE, HG, HH, HI, HJ, HN, HP, HR, HX, ID, IE, IG, IH, II, IJ, IN, IP, IR, IX, JD, JE, JG, JH, JI, JJ, JN, JP, JR, JX, ND, NE, NG, NH, NI, NJ, NN, NP, NR, NX, PD, PE, PG, PH, PI, PJ, PN, PP, PR, PX, RD, RE, RG, RH, RI, RJ, RN, RP, RR, RX, SD, SE, SG, SH, SI, SJ, SN, SP, SR, SX
A0998 (replaced T2006) - Amb. response & treatment, no transport	$45; 1 unit = 1 base rate	QL - Patient declared dead upon amb. arrival; OR basic life support assessment of recipient's condition made, but no treatment rendered.
A0998	$96; 1 unit = 1 base rate	UA - Amb. team renders advanced life support according to medical protocol; patient not transported
A0998	$75; 1 unit = 1 base rate	UB - (replaced 52 on 4/01/06) - Amb. team renders basic life suport according to medical protocol; patient not transported.
A0998	ALS - $271.86; 1 unit = 1 base rate BLS - $262.01; 1 unit = 1 base rate	UD - ALS - Patient expired at scene despite treatment by amb. team U8 - BLS - Patient expired at scene despite treatment by amb. team
	Non-Emergency Transportation	
A0100 - Non-emergency Transportation taxi - Modifier to be used to transport client only; mileage can only be calculated when client in vehicle. Modifiers identify origin and destination of transport. Refer to Medicaid Transportation Policy 8.324.7 for covered services and service limitations.	$1.68/mile - $230 limit paid per 1-way trip; unit = 1 mile; bill each 1-way trip	DD, DE, DG, DH, DI, DJ, DN, DP, DR, DX, ED, EE, EG, EH, EI, EJ, EN, EP, ER, EX, GD, GE, GG, GH, GI, GJ, GN, GP, GR, GX, HD, HE, HG, HH, HI, HJ, HN, HP, HR, HX, ID, IE, IG, IH, II, IJ, IN, IP, IR, IX, JD, JE, JG, JH, JI, JJ, JN, JP, JR, JX, ND, NE, NG, NH, NI, NJ, NN, NP, NR, NX, PD, PE, PG, PH, PI, PJ, PN, PP, PR, PX, RD, RE, RG, RH, RI, RJ, RN, RP, RR, RX, SD, SE, SG, SH, SI, SJ, SN, SP, SR, SX
A0100	$1.68/mile - $230 limit paid each 1-way trip; unit = 1 mile; bill each 1-way trip	UK - Modifier identifies 1st family member transported to client (participating in therapy) - The physician must attest to the need for family therapy in writing.
A0100	$0.58/mile - $115 limit paid each 1-way trip; unit = 1 mile; bill each 1-way trip	U2, U3, U4 - Modifiers identify 2nd, 3rd & 4th family members transported to client (participating in therapy) - The physician must attest to the need for family therapy in writing.

A0130 - Non-ER Transportation - w/c van - Modifier to be used to transport client only; mileage can only be calculated when client in vehicle. Modifiers identify origin and destination of transport. Refer to Medicaid Transportaiton Policy 8.324.7 for covered services and service limitations.	$1.68/mile - $230 limit paid per 1-way trip; unit = 1 mile; bill each 1-way trip	DD, DE, DG, DH, DI, DJ, DN, DP, DR, DX, ED, EE, EG, EH, EI, EJ, EN, EP, ER, EX, GD, GE, GG, GH, GI, GJ, GN, GP, GR, GX, HD, HE, HG, HH, HI, HJ, HN, HP, HR, HX, ID, IE, IG, IH, II, IJ, IN, IP, IR, IX, JD, JE, JG, JH, JI, JJ, JN, JP, JR, JX, ND, NE, NG, NH, NI, NJ, NN, NP, NR, NX, PD, PE, PG, PH, PI, PJ, PN, PP, PR, PX, RD, RE, RG, RH, RI, RJ, RN, RP, RR, RX, SD, SE, SG, SH, SI, SJ, SN, SP, SR, SX
A0130	$1.68/mile - $230 limit paid per 1-way trip; unit = 1 mile; bill each 1-way trip	UK - Modifier identifies 1st family member transported to client (participating in therapy) - The physician must attest to the need for family therapy in writing.
A0130	$0.58/mile - $115 limit paid per 1-way trip; unit = 1 mile; bill each 1-way trip	U2, U3, U4 - Modifiers identify 2nd, 3rd & 4th family members transported to client (participating in therapy) - The physician must attest to the need for family therapy in writing.
T2001 - Non-ER Transportation - Pt. Attendant/Escort - Mileage can only be calculated when client in vehicle. Modifiers identify origin and destination of transport. The physician must attest to the need for an attendant in writing. Refer to Medicaid Transportation Policy 8.324.7 for covered services and service limitations.	$0.58/mile - $115 limit paid per 1-way trip; unit = 1 mile; bill each 1-way trip	DD, DE, DG, DH, DI, DJ, DN, DP, DR, DX, ED, EE, EG, EH, EI, EJ, EN, EP, ER, EX, GD, GE, GG, GH, GI, GJ, GN, GP, GR, GX, HD, HE, HG, HH, HI, HJ, HN, HP, HR, HX, ID, IE, IG, IH, II, IJ, IN, IP, IR, IX, JD, JE, JG, JH, JI, JJ, JN, JP, JR, JX, ND, NE, NG, NH, NI, NJ, NN, NP, NR, NX, PD, PE, PG, PH, PI, PJ, PN, PP, PR, PX, RD, RE, RG, RH, RI, RJ, RN, RP, RR, RX, SD, SE, SG, SH, SI, SJ, SN, SP, SR, SX
A0180 - Non-ER Transportation - Lodging - There must be written attestation from the physician of the need for care out of the community.	$49.61; 1 unit = 1 night	No modifier required
A0190 - Non-ER Transportation - Meals - There must be written attestation from the physician of the need for care out of the community.	$7.20; 1 unit = 1 meal	No modifier required
A0200 - Non-ER Transportation - Ancillary; lodging - escort - There must be written attestation from the physician of the need for care out of the community and the need for attendant.	$49.61; 1 unit = 1 night	UK - Attendant for In-patient Recipient U - Attendant in Separate Room
A0210 - Non-ER Transportation - Meals - Attendant - There must be written attestation from the physician of the need for care out of the community and the need for an attendant.	$7.20 - Medicaid only pays for 1 attendant; 1 unit = 1 meal	U1, U2, U3 - Modifiers identify 1st, 2nd, and 3rd attendants

TRANSPORTATION SERVICES INCLUDING AMBULANCE A0000-A0999

This code range includes ground and air ambulance, nonemergency transportation (taxi, bus, automobile, wheelchair van), and ancillary transportation-related fees.

HCPCS Level II codes for ambulance services must be reported with modifiers that indicate pick-up origins and destinations. The modifier describing the arrangement (QM, QN) is listed first. The modifiers describing the origin and destination are listed second. Origin and destination modifiers are created by combining two alpha characters from the following list. Each alpha character, with the exception of X, represents either an origin or a destination. Each pair of alpha characters creates one modifier. The first position represents the origin and the second the destination. The modifiers most commonly used are:

D	Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than 1819 facility)
G	Hospital-based ESRD facility
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Free standing ESRD facility
N	Skilled nursing facility (SNF)
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office on way to hospital (destination code only)

Note: Modifier X can only be used as a designation code in the second position of a modifier.

See S0215. For Medicaid, see T codes and T modifiers.

E **A0021** **Ambulance service, outside state per mile, transport (Medicaid only)**

E **A0080** **Nonemergency transportation, per mile — vehicle provided by volunteer (individual or organization), with no vested interest**

E **A0090** **Nonemergency transportation, per mile — vehicle provided by individual (family member, self, neighbor) with vested interest**

E **A0100** **Nonemergency transportation; taxi**

E **A0110** **Nonemergency transportation and bus, intra- or interstate carrier**

E **A0120** **Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems**

E **A0130** **Nonemergency transportation: wheelchair van**

E **A0140** **Nonemergency transportation and air travel (private or commercial) intra- or interstate**

E **A0160** **Nonemergency transportation: per mile — caseworker or social worker**

E **A0170** **Transportation ancillary: parking fees, tolls, other**

E **A0180** **Nonemergency transportation: ancillary: lodging, recipient**

E **A0190** **Nonemergency transportation: ancillary: meals, recipient**

E **A0200** **Nonemergency transportation: ancillary: lodging, escort**

E **A0210** **Nonemergency transportation: ancillary: meals, escort**

E **A0225** **Ambulance service, neonatal transport, base rate, emergency transport, one way**
MED: 100-4,1,10.1.4.1

E ☑ **A0380** **BLS mileage (per mile)**
See code(s): A0425
MED: 100-2,6,10; 100-4,1,10.1.4.1

A **A0382** **BLS routine disposable supplies**

A **A0384** **BLS specialized service disposable supplies; defibrillation (used by ALS ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances)**

E ☑ **A0390** **ALS mileage (per mile)**
See code(s): A0425
MED: 100-4,1,10.1.4.1

A **A0392** **ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed in BLS ambulances)**

A **A0394** **ALS specialized service disposable supplies; IV drug therapy**

A **A0396** **ALS specialized service disposable supplies; esophageal intubation**

A **A0398** **ALS routine disposable supplies**

WAITING TIME TABLE

Units	Time
1	1/2 to 1 hr.
2	1 to 1-1/2 hrs.
3	1-1/2 to 2 hrs.
4	2 to 2-1/2 hrs.
5	2-1/2 to 3 hrs.
6	3 to 3-1/2 hrs.
7	3-1/2 to 4 hrs.
8	4 to 4-1/2 hrs.
9	4-1/2 to 5 hrs.
10	5 to 5-1/2 hrs.

A **A0420** **Ambulance waiting time (ALS or BLS), one-half (1/2) hour increments** ⦸

A **A0422** **Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation** ⦸

A **A0424** **Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)** ⦸
Pertinent documentation to evaluate medical appropriateness should be included when this code is reported.

A **A0425** **Ground mileage, per statute mile**
MED: 100-2,6,10; 100-2,10,20; 100-4,1,10.1.4.1

A **A0426** **Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)**
MED: 100-2,6,10; 100-2,10,20; 100-4,1,10.1.4.1

A **A0427** **Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 — emergency)**
MED: 100-2,6,10; 100-2,10,20; 100-4,1,10.1.4.1

A **A0428** **Ambulance service, basic life support, nonemergency transport, (BLS)**
MED: 100-2,6,10; 100-2,10,20; 100-4,1,10.1.4.1

A **A0429** **Ambulance service, basic life support, emergency transport (BLS, emergency)**
MED: 100-2,6,10; 100-2,10,20; 100-4,1,10.1.4.1