HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

MEDICAID TRANSPORTATION VERIFICATION FORM-295

(Must be completed for each new transport)

This form must be retained in the provider's file

Section 1 – CLIENT DECLARATION

Recipient Name:	Recipient ID:	Birth Date
Address – *No. & Street/PO 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 medical 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 _____ to _____
(Street Address, City State) *(Street Address, City State)*

TRANSPORTATION FOR (Check applicable box) ☐ Medical Treatment ☐ Other (Specify) _____

Printed Name of Physician _____

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

Section 3 – TRANSPORTATION PROVIDER

As 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** ☐ Yes ☐ No	**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 the other civil and/or criminal actions as appropriate.