

Iowa Department of Human Services
Medical Transportation Claim

I. IDENTIFICATION (to be completed by the member)

Medicaid member's name	Phone number	Medicaid number	
Address	City	State	Zip

II. TRIP INFORMATION (to be completed by the member or guardian)

Name of individual or provider providing transportation				
Address of individual providing transportation if different from member Street address		City	State	Zip
<input type="checkbox"/> Own car <input type="checkbox"/> A friend or relative drove <input type="checkbox"/> Nursing facility <input type="checkbox"/> Public provider Name:		Total miles, round trip	Charges	
Dates of trip		Time of departure	Time of return	<input type="checkbox"/> Meals \$ _____ Includes escort: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Lodging \$ _____ Includes escort: <input type="checkbox"/> Yes <input type="checkbox"/> No
From street address		City	State	Zip

III. MEDICAL SERVICES (to be completed by the Medicaid provider of medical care)

Name, address and phone of medical provider	<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Mayo Clinic
	<input type="checkbox"/> Dentist	<input type="checkbox"/> Lab
	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Mental health therapy
	<input type="checkbox"/> Family doctor	<input type="checkbox"/> Physical therapy
	<input type="checkbox"/> Doctor-specialist	<input type="checkbox"/> Psychiatrist
	<input type="checkbox"/> Hospital	<input type="checkbox"/> Psychologist
	<input type="checkbox"/> Hospital-specialist	<input type="checkbox"/> Other:
	<input type="checkbox"/> U. of Iowa hospitals	
I certify that I provided service to the member on the dates set forth above. Signature of Provider (or authorized representative)		Dates of visits:
		Time in:
		Time out:
Is the member required to stay overnight? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is an escort required? <input type="checkbox"/> Yes <input type="checkbox"/> No

IV. CERTIFICATION BY MEMBER

I certify that I or the person I represent received the medical transportation as set forth above. I authorize the Department of Human Services to contact the provider of transportation or medical services to verify this statement or get more information if necessary.

Signature of member or representative	Date
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V. LOCAL OFFICE USE ONLY

<input type="checkbox"/> Approved	Amount	\$ _____	Explanation:
<input type="checkbox"/> Partially Approved	Amount	\$ _____	Explanation:
<input type="checkbox"/> Denied	Amount	\$ _____	Explanation:

Signature of worker	Worker number	Date
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(See other side for additional information and instructions.)

Medical Transportation Claim

Procedure to Obtain Payment

This form must be submitted to your County Department of Human Services for each trip for which you are claiming payment, i.e., a separate form for each separate trip. Unless you make more than one trip to a specific provider of service in one calendar month, in which case you may, if you wish, report all the trips to that provider during the month on one claim form in Section II and the provider will enter the dates of all visits that month in Section III. The form should be delivered or mailed to your local County Department of Human Services as soon as possible following completion of each trip to receive medical care. **PAYMENT CANNOT BE MADE ON CLAIMS WHERE MORE THAN NINETY (90) DAYS ELAPSE BETWEEN THE DATE THE TRANSPORTATION TOOK PLACE AND THE DATE THE CLAIM IS RECEIVED IN THE COUNTY OFFICE OF THE DEPARTMENT OF HUMAN SERVICES.** In most instances payment will be made directly to you by check from the Iowa Department of Human Services.

We would suggest that you retain a copy of the claim for your records.

INSTRUCTIONS FOR COMPLETING THE CLAIM

- I. IDENTIFICATION** - This section is to be completed by you or someone acting in your behalf. Enter your name, phone number, address and state ID number.
- II. TRIP INFORMATION** - This section is to be completed by you. Enter the name and address of individual or provider who provided transportation. Check the box next to the way you were transported and the date of the trip. The total miles traveled round trip must be entered and the charge made to you by the provider of transportation. If this was a flat sum, you should enter the amount. If the charge was based on gasoline, the amount for gas should be entered. The beginning point of the transportation should be entered. List meals and lodging for each trip along with costs incurred.
- III. MEDICAL SERVICES** - This section is to be completed by the provider of medical services (doctor, dentist, hospital, etc.). The provider or some designated person in the provider's office should enter his/her signature. Note: If service from more than one provider of medical care is received during the trip, information concerning only one of the providers needs to be entered in this section.
- IV. CERTIFICATION BY RECIPIENT** - You, or the person acting in your behalf, should enter your signature and the date in the space provided. You will note that if the County Department has questions concerning the mileage or the charges submitted, you are authorizing them to contact the provider of transportation or medical services for further information or verification.
- V. COUNTY USE ONLY** - Do not write in this space. It is for the use of the County Department.