MEDICAID TRANSPORTATION
VERIFICATION OF RECEIPT OF MEDICAID COVERED SERVICE

TO: MEDICAID ENROLLED PROVIDER

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 THE TRANSPORT.

PATIENT NAME: ____________________________________________________________

MEDICAID ID #: _____________________________________________________________

DATE OF APPOINTMENT: ____________________________________________________

THIS IS TO CERTIFY THAT THE ABOVE NAMED PATIENT VISITED THIS OFFICE OR FACILITY AND RECEIVED A MEDICAID COVERED SERVICE.

NAME OF MEDICAID PROVIDER/FACILITY AND PHONE NUMBER:

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SIGNATURE OF PERSON COMPLETING FORM ON BEHALF OF PROVIDER:

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THIS FORM MUST BE RETURNED TO THE YADKIN COUNTY HUMAN SERVICES AGENCY SOCIAL SERVICES DIVISION WITHIN TEN (10) DAYS FOLLOWING MEDICAID APPROVED APPOINTMENTS. PLEASE FAX FORM BACK TO 336-849-7937. FAILURE TO RETURN THIS FORM COULD RESULT IN AN UN-EXCUSED NO-SHOW.