



MEDICAL ASSISTANCE DIVISION

MEDICAID TRANSPORTATION VERIFICATION FORM

This form must be retained in the provider's file

CLIENT DECLARATION

Recipient Name		Recipient I.D.	Birth Date
ADDRESS - No. & Street/P.O. Box/Rural Route/Apt.. No.			
City	State	Zip Code	
<input type="checkbox"/> I do not have a vehicle and I do not have anyone to transport me to my medical service provider. <input type="checkbox"/> 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.			
Receipt Signature To Facility			Date
Receipt Signature From Facility			

MEDICAL PROVIDER

This is to certify that _____ (Name of Client)

Medicaid client number _____ was transported on _____ (Date)

from _____ to _____ (Street Address)

TRANSPORTATION FOR (Check applicable box):

Medical Treatment Pharmacy Other (Specify)

Signature of Physician or Medical Practitioner	Date of Signature	Provider Number
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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.

Total Miles:	Total Amount Due:
Company Name CARE-A-VAN Services, Inc.	Telephone Number 505/397/2801
ADDRESS - No. & Street PO BOX 6044 2827 N. Dal Paso, #120 Hobbs, NM 88240	State _____ Zip Code _____
Signature of Driver	Date of Signature
<p>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.</p>	