DSS-OS-951.0 12/17

Provider #: 5338

CHEYENNE RIVER SUPPORT SERVICES

PO Box 590, Eagle Butte, SD 57625 Ph (605) 964-6565 Fax (605) 964-6554

SD MEDICAID NON-EMERGENCY MEDICAL TRAVEL (NEMT)
REQUEST FOR TRAVEL ADVANCE

RECIPIENT INFORMATION

Medicaid Recipient's Name:	
Recipient's Date of Birth:	Medicaid ID Number:
Recipient's Address:	
Parent/Guardians Name:	Phone Number:

PROVIDER INFORMATION

Name of Medical Facility:
Address and Phone Number:
Name of Doctor:
Type of Provider (GP, Cardiologist, Dentist, etc.):
Purpose of visit (please be specific):

TRIP INFORMATION

Date of appointment:	Time of appointment:
From (city):	To (city):
Departure Date:	Return Date:
Mode of transportation for this medical trip: ☐ Private vehicle ☐ Other _____	
COMPLETE FOR OVERNIGHT STAYS ONLY	
Overnight: ☐ Yes ☐ No	If yes, how many nights:
Will the recipient be hospitalized? ☐ Yes ☐ No ☐ Unknown	If yes, please list admit date:

Lodging Information:

Recipient:	Driver/Escort:
◯ Motel (receipt required)	◯ Motel (receipt required)
◯ Family/Friend	◯ Family/Friend
◯ Inpatient Hospital Stay	◯ Will Stay at Hospital
◯ Ronald McDonald House	◯ Ronald McDonald House

Have you received any financial assistance from another source to help with this trip? ☐ YES ☐ NO

If yes, who? _____ Amount: $ _____

Comments: _____

_____

Signature _____ **Date** _____

(person completing form)

AMOUNT ASSISTED BY CHEYENNE RIVER SUPPORT SERVICES FOR THIS MEDICAL TRIP

MILEAGE: _____

LODGING: _____

MEALS: _____

TOTAL: _____

Please send form back to NEMT by: **Fax: (605) 773-8461**

Email: DSS.EBTSTATEOFFICE@state.sd.us

*** A reimbursement determination will be made upon completion of the medical trip, receipt of all required forms and documentation, and verification of covered services. This is not a guarantee of reimbursement.***

DSS State Office Use Only

CLAIM # _____ **WORKER:** _____