Medicaid Transportation Monitoring Report

_____*Wake*_____County DSS

Recipient Name_____

Medicaid ID Number_____Date of Transport_____

Vendor Used_____

Medical Provider Name_____

Medical Provider Telephone Number_____

Please circle one answer for each question below.

Was recipient authorized for Medicaid on trip date?   **Yes** or   **No**

Was recipient in an eligible Medicaid category?   **Yes** or   **No**

Was recipient transported to a Medicaid Enrolled Provider?   **Yes** or   **No**

Did recipient receive a Medicaid covered service?   **Yes** or   **No**

DMA-5048, Transportation Exception Verification Form in the file?   **Yes**   or   **No**   or **N/A**

Current DMA-5046, Notice of Rights in the file?   **Yes** or   **No**

Current DMA-5047, Medicaid Assessment in the file?   **Yes** or   **No**

Current DMA-5024, Transportation Assessment Notification in the file?   **Yes** or   **No**

Calculation of the reimbursement for the trip/related expenses done correctly?   **Yes** or   **No**

Was there a DMA-5019, Denial of Transportation Request provided to the recipient?   **Yes** or **No** or **N/A**

Trip coded correctly for reimbursement on the DMA-2056, Transportation Log?   **Yes** or   **No**

Review Date_____

Name of Monitor_____*Oliver Abreu*_____

DMA-5078
1/1/2012