

# MEDICAID TRANSPORTATION EXCEPTION VERIFICATION

## Section 1 – Identifying Information (DSS completes)

Wake County Department of Social Services Date 00/00/2018

Beneficiary Name FirstName LastName Address DOB: 09/02/1989

Phone Medicaid ID 000000000P

Caseworker Name Caseworker Phone

## Section 2 – Medicaid Beneficiary Consent to Release Information

I, \_\_\_\_\_, have requested Medicaid transportation assistance.

I authorize \_\_\_\_\_ to release information requested below to the  
(doctor, clinic, other medical provider name)  
Department of Social Services.

This authorization is valid for up to one year from the date signed. I understand that I may revoke this authorization at any time by submitting a written request to the County DSS. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

Medicaid beneficiary's or representative's signature

Date

**Note to beneficiary:** bring this form to your provider to complete and have your provider fax it to DSS at \_\_\_\_\_. Forms returned directly to DSS by the beneficiary will not be considered.

## Section 3 – Exception Requested and Justification

Medicaid regulations limit transportation to the closest appropriate provider by the most economical means available. You only need to complete this form if an exception is required.

The Medicaid beneficiary named above has requested:

- ☒ Transportation to a provider located outside of the county's normal service area
- ☐ A special mode of transportation (attendant, service animal, vehicle type, etc.)
- ☐ Lodging

> Duration of Need: From: \_\_\_\_\_ to \_\_\_\_\_ or Permanent \_\_\_\_\_

If the beneficiary is requesting transport to a provider located outside the county's normal service area: Please provide the name, address and phone number of the medical provider to whom the beneficiary is being referred;

> Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

> Please explain why this beneficiary cannot be served by a provider within the normal county service area.

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### Section 3 – Exception Requested and Justification

If the beneficiary is requesting a special mode of transportation or has a special need, please explain:

Indicate the special mode or need? (attendant, service animal, vehicle type, other) \_\_\_\_\_

Why is this accommodation necessary?

\_\_\_\_\_  
\_\_\_\_\_

If the beneficiary will need lodging during his/her treatment, please explain why the beneficiary will have to stay overnight near the treatment facility (to be completed by provider at facility).

\_\_\_\_\_  
\_\_\_\_\_

For how long (number of nights) will the beneficiary need to remain near the facility?

From \_\_\_\_\_ To \_\_\_\_\_

### Section 4 -- Attestation

To the best of my knowledge, the above statements are true and correct.

Name of provider completing form (print): \_\_\_\_\_ Phone \_\_\_\_\_

> Provider's Signature: \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*Incomplete or inaccurate forms will not be approved, and could delay transportation to medical services\*\*\*