wisconsin Medicaid update
and BadgerCare
November 2006 ● No. 2006-92
Wisconsin Medicaid and BadgerCare Information for Providers

To:
Chiropractors
Dentists
Family Planning Clinics
HealthCheck Providers
Nurse Midwives
Nurse Practitioners
Opticians
Optometrists
Physician Assistants
Physician Clinics
Physicians
Podiatrists
Specialized Medical Vehicle Providers
HMOs and Other Managed Care Programs

Changes Effective January 1, 2007, for Specialized Medical Vehicle Services Providers and Prescribers

The following changes will be effective for dates of service on and after January 1, 2007:

- Prescriptions will no longer be required for specialized medical vehicle (SMV) trips that extend beyond Wisconsin Medicaid's upper mileage limits.
- Prior authorization will no longer be required for SMV services that extend beyond the upper mileage limits.
- Providers will be required to use the revised Certification of Need for Specialized Medical Vehicle Transportation form, HCF 1197 (11/06). The validity of the form for indefinitely disabled and legally blind recipients has increased from 365 days (one year) to three years (36 months) from the date the medical care provider signs the form.
- Providers will be required to use the revised Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification form, HCF 1050 (11/06). Refer to the "Changes to the Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification Form" section of this *Wisconsin Medicaid and BadgerCare Update* for specific form changes.

This *Update* also clarifies when SMV providers may submit claims for unloaded mileage.

Prescriptions No Longer Required for Extended Travel

Effective for dates of service (DOS) on and after January 1, 2007, prescriptions are no longer required for specialized medical vehicle (SMV) trips that extend beyond Wisconsin Medicaid's one-way upper mileage limits (40 or 70 miles, depending on the county in which the trip originates). Therefore, the following providers are no longer required to write prescriptions for extended travel to Medicaid-covered health services:

- Chiropractors.
- Dentists.
- Family planning clinics.
- HealthCheck agencies.
- Nurse midwives.
- Nurse practitioners.
- Optometrists/opticians.
- Physicians.
- Physician assistants.
- Podiatrists.

Prior Authorization No Longer Required

Effective for DOS on and after January 1, 2007, prior authorization will no longer be

required for SMV trips that extend beyond the upper mileage limits. As a result, SMV providers will no longer be required to indicate modifier "TN" on claims for DOS on and after January 1, 2007.

Changes to the Certification of Need for Specialized Medical Vehicle Transportation Form

Effective for DOS on and after January 1, 2007, providers will be required to use the revised Certification of Need for Specialized Medical Vehicle Transportation form, HCF 1197 (11/06). The following changes were made to the form:

- Element 3 (optional) has been added for medical providers to indicate the recipient's date of birth.
- Element 5 has been modified. The validity of the form for indefinitely disabled and legally blind recipients will increase from 365 days (one year) to three years (36 months) from the date the medical care provider signs the form. The form is still valid for no more than 90 days for recipients with a temporary disability.
- Element 6 has been added so medical providers may indicate if the recipient requires the use of a wheelchair or scooter.

Certification of Need for Specialized Medical Vehicle Transportation forms obtained before January 1, 2007, are valid until they expire, which is 365 days from the date on which the form is signed by the medical care provider. Providers are not required to redo or transfer existing certifications to this new form until their existing certification is due to be renewed. The revised Certification of Need for Specialized Medical Vehicle Transportation Completion Instructions and form may be obtained from Attachments 1 and 2 of this *Wisconsin Medicaid and BadgerCare Update* or from the Medicaid Web site.

Changes to the Specialized Medical Vehicle Transportation Trip Ticket/ Medical Care Verification Form

Effective for DOS on and after January 1, 2007, SMV providers will be required to use the revised Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification form, HCF 1050 (11/06). The following changes were made to the form:

- Some elements (or parts of elements) are now optional. For example:
  - ✓ The recipient's Medicaid identification number is now optional.
  - ✓ Complete addresses continue to be required, but the inclusion of the ZIP code is optional in all cases.
  - ✓ The driver's first and last names are still required, but the driver's middle initial is optional.
- A locally assigned unique identifier for the driver is now acceptable. If an identifier is used in place of the driver's name, the provider's file must include a cross-reference to the driver's full name.
- When a locally assigned or fleet number is used for a vehicle, the provider's file must include a cross-reference to either the vehicle identification number or to the vehicle license plate number.

The revised Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification Completion Instructions and form may be obtained from Attachments 3 and 4 of this *Update* or from the forms page of the Medicaid Web site. To be accepted by Wisconsin Medicaid, all required elements of the form must be completed.

As a reminder, Wisconsin Medicaid does not reimburse for excessive mileage resulting from indirect routes to and from destinations. In addition to documenting the actual odometer

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readings for trips with multiple riders, providers are required to document the mileage for the shortest route available (i.e., the most direct route) for each trip and maintain this documentation in their records.

Clarification of Unloaded Mileage

Wisconsin Medicaid does not reimburse SMV providers for the first 20 miles of unloaded mileage. Although SMV providers are required to document the total unloaded mileage for a trip in their records, providers may only submit claims for unloaded mileage beyond 20 miles. For example, if a trip includes 35 miles of unloaded mileage, the claim should indicate an unloaded mileage of only 15 miles. Providers are reminded to use modifier "TP" to indicate unloaded mileage on claims.

Refer to the July 2003 *Update* (2003-63), titled "Changes to local codes, paper claims, and prior authorization for specialized medical vehicle services in conjunction with HIPAA requirements," for a sample claim and illustration of submitting claims for unloaded mileage over 20 miles.

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

PHC 1250

ATTACHMENT 1
Certification of Need for Specialized Medical Vehicle Transportation Completion Instructions

(A copy of the "Certification of Need for Specialized Medical Vehicle Transportation Completion Instructions" is located on the following page.)

WISCONSIN MEDICAID
CERTIFICATION OF NEED FOR SPECIALIZED MEDICAL VEHICLE TRANSPORTATION COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration, such as determining eligibility of the applicant, processing prior authorization requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is mandatory. Wisconsin Medicaid will not accept alternate versions of this form. Completed forms that appear to be altered in *any way* will not be accepted. For further instructions or questions, refer to the Specialized Medical Vehicle Handbook or contact Provider Services at (800) 947-9627 or (608) 221-9883.

INSTRUCTIONS — SPECIALIZED MEDICAL VEHICLE PROVIDER

1. Give a copy of this form to the recipient requesting specialized medical vehicle (SMV) transportation for his or her medical care provider (evaluator) to complete if he or she does not already have a copy. Wisconsin Medicaid will not accept alternate versions of this form. Completed forms that appear to be altered in *any way* will not be accepted. The form is valid only if every element is completed and has the medical provider's original signature (i.e., not a stamped or photocopied signature.) Wisconsin Medicaid will not accept incomplete forms or forms without original signatures; however, faxes from the medical care provider are acceptable.

2. Accept the form only if the date of receipt is within 14 working days from the date the medical care provider (evaluator) signs the form. If the form indicates that the recipient is temporarily disabled, the certification of need is valid for the period indicated on the form in Element 4. This period must be no more than 90 days from the date the medical care provider signed the form. If the form indicates that the recipient is indefinitely disabled or legally blind, the certification of need is valid for three years (36 months) from the date the medical care provider (evaluator) signed the form.

3. Retain the completed original in the recipient's file for five years from the last date of service billed under this form. Failure to retain this form may result in recovery of Medicaid payment for the SMV services provided to the recipient.

INSTRUCTIONS — MEDICAL CARE PROVIDER (EVALUATOR) COMPLETING FORM

Type or print clearly.

Section I
Enter the recipient's full name and Wisconsin Medicaid identification number; including a middle initial is optional. The date of birth is also optional.

Section II
Determine whether or not the recipient has a condition that contraindicates safe travel by common carrier such as accessible mass transit, taxi, or private vehicle. If not, **stop** here and refer the recipient to the Medicaid transportation coordinator at his or her county/tribal social or human services agency. If yes, complete Sections III and IV.

Sections III and IV
Complete Sections III and IV if the recipient's condition contraindicates safe travel by common carrier such as accessible mass transit, taxi, or private vehicle. Sign and date Section IV only if the provider has evaluated this recipient and finds that he or she is legally blind or disabled and cannot travel safely by common carrier, such as a private vehicle or accessible mass transit. The provider's signature must be original and cannot be stamped or photocopied. Give the original form to the recipient and keep a copy.

Definitions

Indefinitely Disabled — As stated in HFS 107.23(1)(c)1, Wis. Admin. Code, "indefinitely disabled" means a chronic, debilitating physical impairment which includes an inability to ambulate without personal assistance or requires the use of a mechanical aid such as a wheelchair, a walker or crutches, or a mental impairment which includes an inability to reliably and safely use common carrier transportation because of organic conditions affecting cognitive abilities or psychiatric symptoms that interfere with the recipient's safety or that might result in unsafe or unpredictable behavior. These symptoms and behaviors may include the inability to remain oriented to correct embarkation and debarkation points and times and the inability to remain safely seated in a common carrier cab or coach.

Temporarily Disabled — A condition that meets the above definition but is expected to exist only for a limited time.

ATTACHMENT 2
Certification of Need for Specialized Medical Vehicle Transportation

(A copy of the “Certification of Need for Specialized Medical Vehicle Transportation” form is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1197 (11/06)

WISCONSIN MEDICAID
CERTIFICATION OF NEED FOR SPECIALIZED MEDICAL VEHICLE TRANSPORTATION

Instructions: Type or print clearly. All areas of this form must be completed and signed by a medical care provider (evaluator) to verify the need for specialized medical vehicle (SMV) transportation. Only a physician, physician assistant, nurse midwife, or nurse practitioner may be an evaluator and sign this form. Refer to the Certification of Need for Specialized Medical Vehicle Transportation Completion Instructions, HCF 1197A, for information on completing this form.

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Recipient Medicaid Identification Number (10 digits)	3. Recipient's Date of Birth (MM/DD/YY) (Optional)

SECTION II — ELIGIBILITY FOR SPECIALIZED MEDICAL VEHICLE TRANSPORTATION

4. Does the recipient have a physical / mental impairment that contraindicates safe travel by common carrier such as accessible mass transit, taxi, or private vehicle?

   If "**no**," then **STOP** here. Do **not** complete or sign this form. Instead, refer the recipient to the Medicaid transportation coordinator at his or her county/tribal social or human services department.

   If "**yes**," then complete Sections III and IV of this form.

SECTION III — DIAGNOSIS INFORMATION AND VERIFICATION OF MEDICAL CONDITION

5. I have evaluated this recipient and certify that he or she is one of the following. (Refer to the completion instructions of this form for definitions of indefinitely and temporarily disabled.) (Check one.)

   ❑ Indefinitely disabled. This form is valid for three years (36 months) from the date signed by the medical care provider.

   ❑ Legally blind. This form is valid for three years (36 months) from the date signed by the medical care provider.

   ❑ Temporarily disabled. This form is valid for no more than 90 days from the date signed by the medical care provider. (This certification of need may be renewed after 90 days, if necessary.)

   If less than 90 days, state expected duration of disability: _____ days

6. Does the recipient require the use of a wheelchair or scooter?

   ❑ Yes ❑ No

7. Explain why the recipient's physical / mental condition requires transportation in a SMV. Include the diagnosis, if possible.

SECTION IV — MEDICAL CARE PROVIDER (EVALUATOR) INFORMATION

I have evaluated this recipient and certify that he or she has a condition that contraindicates safe travel by common carrier, such as private vehicles or mass-transit services, and requires the use of an SMV for transportation to receive medical services.

8. **SIGNATURE** — Evaluator	9. Date Signed — Evaluator

10. Name — Evaluator (Print)	11. Position Title — Evaluator

12. Universal Provider Identification Number (UPIN) or Wisconsin Medicaid Provider Number

ATTACHMENT 3
Specialized Medical Vehicle Transportation Trip Ticket/ Medical Care Verification Completion Instructions

(A copy of the "Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification Completion Instructions" is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1050A (11/06)

STATE OF WISCONSIN
HFS 107.23, Wis. Admin. Code

WISCONSIN MEDICAID
SPECIALIZED MEDICAL VEHICLE TRANSPORTATION TRIP TICKET / MEDICAL CARE VERIFICATION COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but not be limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration, such as determining eligibility of the applicant, processing prior authorization requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Provision of the required information requested on this form is mandatory for each trip. However, the use of an exact version of the form is voluntary and providers may develop their own form as long as it includes all of the required information on this form. Elements labeled “conditional” must be included if applicable to the trip. Information identified as “optional” is retained at the provider’s discretion.

For further information about specialized medical vehicle (SMV) documentation, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

INSTRUCTIONS

Type or print clearly. Wisconsin Medicaid requires a completed Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification form for each transport.

SECTION I — PROVIDER INFORMATION

Element 1 — Specialized Medical Vehicle Company (Required)
Enter the name of the company by which the SMV is owned.

Element 2 — Wisconsin Medicaid Provider Number (Eight Digits) (Required)
Enter the billing provider’s eight-digit Medicaid provider number.

Element 3 — Date of Trip (MM/DD/YYYY) (Required)
Enter the date on which the trip was made.

Element 4 — Name — Driver (Last, First, Middle Initial) (Required)
Enter one of the following:
- The driver’s last name, first name, and middle initial. The middle initial is optional.
- The locally assigned unique identifier for the driver. The unique identifier is acceptable only if the identifier is documented in the provider’s file with a cross-reference to the driver’s full name. (Including the driver’s middle initial in the cross-reference is optional.)

Element 5 — SIGNATURE — Driver (Required)
The driver is required to sign this element. The month, day, and year the form is signed must also be entered in the element in MM/DD/YY format.

Element 6 — Vehicle Identification or License Plate Number (Required)
Enter one of the following:
- Vehicle identification number (VIN).
- License plate number.
- Locally assigned number (e.g., fleet number). Wisconsin Medicaid requires that the locally assigned number be cross-referenced with either the VIN or license plate number and be documented in the provider’s files.

Element 7 — Name — Second Attendant (Last, First, Middle Initial) (Conditional)
If applicable, enter the last name and first name of the second attendant present in the SMV during the trip. The middle initial is optional.

Element 8 — Prescription for Second Attendant? (Conditional)
Check “Yes” or “No.”

SECTION II — RECIPIENT INFORMATION

Element 9 — Name — Recipient (Last, First, Middle Initial) (Required)
Enter the last name, first name, and middle initial of the recipient. The middle initial is optional.

Element 10 — Recipient Medicaid Identification Number (Optional)
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 11 — Wheelchair or Scooter? (Required)
Check "Yes" or "No."

Element 12 — Cot or Stretcher? (Required)
Check "Yes" or "No."

SECTION III — ORIGINATING TRIP

Element 13 — Address — Dispatch Location (Number, Street, City, State, and ZIP Code) — Unloaded Mileage (Conditional)
Enter the complete address of the dispatch location. The ZIP code is optional.

Element 14 — Odometer Readings — Unloaded Mileage (Conditional)
Record the exact odometer reading at the dispatch location (start) and at the first pick-up location (end).

Element 15 — Total Odometer Reading — Unloaded Mileage (Optional)
Enter the total odometer reading.

Element 16 — Address — Pick-Up Point (Name of Facility, Number, Street, City, State, and ZIP Code) (Required)
Enter the name or type of facility and complete address of the facility at which the recipient was picked up. If the recipient was picked up at a private residence, enter "home" and the complete address of the residence. The ZIP code is optional.

Element 17 — Odometer Reading — Trip Start (Required)
Record the exact odometer reading at the start of the trip.

Element 18 — Time — Trip Start (Required)
Record the trip start time.

Element 19 — Address — Drop-Off Point (Name of Facility, Number, Street, City, State, and ZIP Code) (Required)
Enter the name and complete address of the facility at which the SMV dropped off the recipient. If the recipient was dropped off at a private residence, enter "home" and the complete address of the residence. The ZIP code is optional.

Element 20 — Odometer Reading — Trip End (Required)
Record the exact odometer reading at the recipient's drop-off location.

Element 21 — Time — Trip End (Required)
Record the trip end time.

Element 22 — Waiting Time — Start (Conditional)
Enter the time at which the SMV began waiting for the recipient.

Element 23 — Waiting Time — End (Conditional)
Enter the time at which the SMV stopped waiting for the recipient.

Element 24 — More Than One Medicaid Recipient in Vehicle? (Required)
Check "Yes" or "No."

Element 25 — Name — Primary Rider (Conditional)
Record the name of the individual for whom the standard base rate and mileage will be billed. This field is necessary if the trip includes more than one recipient (multiple rider trip). Record the primary rider's full name. The middle initial is optional.

Element 26 — Total Odometer Reading (Optional)
Enter the total odometer reading.

SECTION IV — RETURN TRIP (Complete this section *only* if information in Sections I and II applies.)
Section IV of the form should be completed *only* if the provider and recipient information for the return trip is the same as the information in Sections I and II. If the provider or recipient information is different, complete a new trip ticket.

Element 27 — Address — Dispatch Location (Number, Street, City, State, and ZIP Code) — Unloaded Mileage (Conditional)
Enter complete address of dispatch location. The ZIP code is optional.

Element 28 — Odometer Readings — Unloaded Mileage (Conditional)
Record the exact odometer reading at the dispatch location (start) and at the first pick-up location (end).

Element 29 — Total Odometer Reading — Unloaded Mileage (Optional)
Enter the total odometer reading.

Element 30 — Address — Pick-Up Point (Name of Facility, Number, Street, City, State, and ZIP Code) (Conditional)
This element is only required if this address is different than the drop-off address entered in Element 19. Enter the name or type of facility and complete address of the facility at which the recipient was picked up. The ZIP code is optional.

Element 31 — Odometer Reading — Trip Start (Required)
Record the exact odometer reading at the start of the trip.

Element 32 — Time — Trip Start (Required)
Record the trip start time.

Element 33 — Address — Drop-Off Point (Name of Facility, Number, Street, City, State, ZIP Code) (Required)
Enter the name and complete address of the facility at which the SMV dropped off the recipient. If the recipient was dropped off at a private residence, enter “home” and the complete address of the residence. The ZIP code is optional.

Element 34 — Odometer Reading — Trip End (Required)
Record the exact odometer reading at the recipient’s drop-off location.

Element 35 — Time — Trip End (Required)
Enter the trip end time.

Element 36 — More Than One Medicaid Recipient in Vehicle? (Required)
Check “Yes” or “No.”

Element 37 — Name — Primary Rider (Conditional)
Record the name of the individual for whom the standard base rate and mileage will be billed. This field is necessary if the trip includes more than one recipient (multiple rider trip). Record the primary rider’s full name. The middle initial is optional.

Element 38 — Total Odometer Reading (Optional)
Enter the total odometer reading.

SECTION V — VERIFICATION OF MEDICAID-COVERED MEDICAL CARE (OPTIONAL)
Specialized medical vehicle providers are strongly encouraged to obtain verification of the medical nature of the trip for the purpose of a future audit by obtaining a signature from the medical service provider or his or her authorized representative.

Element 39 — Name (Printed) — Person Verifying Medicaid-Covered Service
Enter the name of the person who is verifying the Medicaid-covered service.

Element 40 — Position Title — Person Verifying Medicaid-Covered Service
Enter the position title of the person who is verifying the Medicaid-covered service.

Element 41 — SIGNATURE — Person Verifying Medicaid-Covered Service
Enter the signature of the person who is verifying the Medicaid-covered service.

Element 42 — Date Signed — Person Verifying Medicaid-Covered Service
Enter the date on which the person who is verifying the Medicaid-covered service signed the Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification.

ATTACHMENT 4
Specialized Medical Vehicle Transportation Trip Ticket/ Medical Care Verification

(A copy of the "Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification" form is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1050 (11/06)

STATE OF WISCONSIN
HFS 107.23, Wis. Admin. Code

WISCONSIN MEDICAID

SPECIALIZED MEDICAL VEHICLE TRANSPORTATION TRIP TICKET / MEDICAL CARE VERIFICATION

Instructions: Type or print clearly. Refer to the Specialized Medical Vehicle Transportation Trip Ticket / Medical Care Verification Completion Instructions, HCF 1050A, for information on completing this form.

SECTION I — PROVIDER INFORMATION

1. Name — Specialized Medical Vehicle Company	2. Wisconsin Medicaid Provider Number (Eight Digits)	3. Date of Trip (MM/DD/YYYY)
4. Name — Driver (Last, First, Middle Initial)	5. **SIGNATURE** — Driver	

6. Vehicle Identification or License Plate Number	7. Name — Second Attendant (Last, First, Middle Initial)	8. Prescription for Second Attendant? ❑ Yes ❑ No

SECTION II — RECIPIENT INFORMATION

9. Name — Recipient (Last, First, Middle Initial)	10. Recipient Medicaid Identification Number	11. Wheelchair or Scooter? ❑ Yes ❑ No	12. Cot or Stretcher? ❑ Yes ❑ No

SECTION III — ORIGINATING TRIP

13. Address — Dispatch Location (Number, Street, City, State, and ZIP Code) Unloaded Mileage	14. Odometer Readings — Unloaded Mileage _____ Start _____ End	15. Total Odometer Reading — Unloaded Mileage
16. Address — Pick-Up Point (Name of Facility, Number, Street, City, State, and ZIP Code)	17. Odometer Reading — Trip Start	18. Time — Trip Start ❑ a.m. ❑ p.m.
19. Address — Drop-Off Point (Name of Facility, Number, Street, City, State, and ZIP Code)	20. Odometer Reading — Trip End	21. Time — Trip End ❑ a.m. ❑ p.m.

22. Waiting Time — Start ❑ a.m. ❑ p.m.	23. Waiting Time — End ❑ a.m. ❑ p.m.	24. More Than One Medicaid Recipient in Vehicle? ❑ Yes ❑ No	25. Name — Primary Rider	26. Total Odometer Reading

SECTION IV — RETURN TRIP (Complete this section **only** if information in Sections I and II apply.)

27. Address — Dispatch Location (Number, Street, City, State, and ZIP Code) Unloaded Mileage	28. Odometer Readings — Unloaded Mileage _____ Start _____ End	29. Total Odometer Reading — Unloaded Mileage
30. Address — Pick-Up Point (Name of Facility, Number, Street, City, State, and ZIP Code)	31. Odometer Reading — Trip Start	32. Time — Trip Start ❑ a.m. ❑ p.m.
33. Address — Drop-Off Point (Name of Facility, Number, Street, City, State, and ZIP Code)	34. Odometer Reading — Trip End	35. Time — Trip End ❑ a.m. ❑ p.m.

36. More Than One Medicaid Recipient in Vehicle? ❑ Yes ❑ No	37. Name — Primary Rider	38. Total Odometer Reading

SECTION V — VERIFICATION OF MEDICAID-COVERED MEDICAL CARE (OPTIONAL)

39. Name (Printed) — Person Verifying Medicaid Covered Service	40. Position Title — Person Verifying Medicaid Covered Service
41. **SIGNATURE** — Person Verifying Medicaid Covered Service	42. Date Signed — Person Verifying Medicaid Covered Service