A picture containing drawing, sign

Description automatically generated **Rocky Boy Health Center - Application for Medical Travel Assistance**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-

If appointment is for minor D.O.B of minor: \_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number or Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appointment Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date & Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age of Patient: \_\_\_\_\_\_\_\_ Is an escort required? \_\_\_\_\_\_\_\_\_\_\_\_\_

Source of Income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount received monthly: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of People that live in Household: \_\_\_\_\_\_\_\_\_\_

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I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ solemnly swear that the type of income and the amount stated herein is true and accurate, I further understand that I may be prosecuted for any false information that I have provided. I understand I must provide the Transportation Department with receipts for **GAS, MOTEL**, and that I must further **provide** **documentation from the doctor’s office that I did make my appointment.**  **If I do not provide the required documentation the RBHB will attempt collection efforts**.

**I understand that if I do not provide the required documentation requested, I will not be eligible for any further assistance from the Medical Travel Program, I further agree that if I am on Medicaid that the Rocky Boy Health Board can bill Medicaid for the services that have been provided.**

**Signed this \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_year \_\_\_\_\_\_\_\_\_\_.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Applicant Signature Print**

***Do not write below this line for official use only.***

**Eligibility Status: Approved\_\_\_\_\_\_\_\_\_\_\_ Disapproved \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reference number from State of Montana Medicaid: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If patient has no alternative resources, please send information to RBHC – Alt resources.**

**I certify that the applicant has met all the eligibility requirements for the Medical Travel Assistance Program.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Transportation Personal Date**

|  |  |  |
| --- | --- | --- |
| Names | Age | Source of Income |
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\*\*\*PLEASE LIST EVERYONE IN YOUR HOME\*\*\*

**\*\*\*\*\* Medicaid Disclosure \*\*\*\*\***

Travel assistance benefits are funds that help Medicaid members with transportation costs in advance of their medical appointments. These funds help members get to and from medical appointments. When the member meets certain requirements, he/she may get help with mileage, meals, and lodging. These benefits are for members who have Full or Basic Medicaid coverage.

The Rocky Boy Health Center requires our patients to disclose if they are applying for any Medicaid reimbursement. Any reimbursements received from Medicaid must be turned back into the Rocky Boy Health Center Finance Department. Failure to adhere may result in ineligible status from the medical travel assistance program by the Rocky Boy Health Center.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date**

## Medicaid Transportation Services

**PO Box 6488**

**Helena, MT 59604-6488**

**406 443-6100**

# Travel Request Form

Name of Requestor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pick Up or Departure Address (if different from street address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date(s) of Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Return Date (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appointment time (s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are there multiple dates of service? Yes No: Number of trips: \_\_\_\_\_\_\_\_\_

Reason For Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Provider’s Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Going to (Name of Dr, facility, etc): \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If facility, give name of department (i.e. Radiology, ER, Lab etc.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Destination Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Extension/ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete Physical Address of destination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this a round-trip? Yes : No is a travel attendant required? Yes No:

If Yes, give reason for attendant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mode of transportation (check only one box):**

**Patient driving**  **Other Driver** **Bus** **Para-transit Taxi Wheelchair Van Other** (use comments)

Name of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To whom should the check be issued?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payee Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NOTE: ALL TRAVEL REQUESTS ARE SUBJECT TO REVIEW AND AUTHORIZATION PRIOR TO THE SERVICE**

Any special conditions or concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New** Taxi & Wheelchair Van Users – Provide explanation of reason fixed bus or para-transit services are not being used. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fax Line: 800 291-7791 Toll Free Telephone: 800 292-7114**