Form MT-3 (Revised 01/14)

VERIFICATION OF MEDICAL TRANSPORTATION

Single Appointment:	**Weekly Appointments:**
Date of Appointment: _____/_____/_____	Week of Appointments: _____/_____/_____ - _____/_____/_____
Time of Appointment: _____AM / PM	Days Transported: **Sun Mon Tue Wed Thu Fri Sat**

I. RECIPIENT VERIFICATION OF MEDICAL TRANSPORTATION

Transportation Provider Name _____

Recipient's Name_____ Medicaid I.D._____

Recipient's Address _____
Street City State ZIP Code

Appointment Address_____
Street City State ZIP Code

Having no other form of transportation to receive medical treatment under the Medicaid program, I have requested transportation services from the Department of Health and Hospitals. My signature below acknowledges that I am using transportation to keep a medical appointment. I understand that transportation services can only be used to receive medical services. I understand that if I do not sign this request for medical transportation and return it to the transportation provider, the Department of Health and Hospitals or a duly appointed representative may choose to contact me or the medical provider I am being transported to for the verification that I have kept my medical appointment.

_____ _____
Recipient's Signature Date

II. DRIVER VERIFICATION

Check appropriate block(s)

☐ I certify that I was the driver who provided the above named recipient with transportation to the medical facility.

_____ _____
Driver's Signature Date

☐ I certify that I was the driver who provided transportation for the above recipient from the medical facility to the recipient's home.

_____ _____
Driver's Signature Date

III. MEDICAL SERVICE PROVIDER VERIFICATION

This section must be completed by the medical service provider or his/her representative and returned to the transportation provider by the recipient when the recipient is picked up after the medical appointment. Completion of this section by the signature of anyone other than the medical provider or his/her representative who rendered the services is prohibited and may result in prosecution.

☐ I certify that the above named recipient had an appointment(s) on _____ at _____ AM / PM and received medical services. (specify date/dates)

☐ I certify that the above named recipient was in the office on _____/_____/_____ at _____ AM /PM but did not receive medical services because_____

_____

Office Stamp (Optional) _____ Signature and Title _____ Date

INSTRUCTIONS FOR COMPLETION OF FORM MT-3

The MT-3 provides verification that a medical appointment was kept. It is completed by the driver and signed by the recipient, the driver and the medical provider or representative to confirm that the trip was completed. If the recipient does not or will not sign the MT-3, an explanation must be given in the "remarks" section of the claim form (Form 106). Following are instructions for completion of the Form MT-3.

Top Section of MT-3:

Single Appointment – Complete when transportation is for a single appointment date.

- Date of Appointment: indicate date of the medical appointment.
- Time of Appointment: indicate actual time of the medical appointment and circle "AM" or "PM".

Weekly Appointments – Complete when transportation is provided for multiple appointments during a specified week.

- Week of Appointments: indicate the beginning and ending days of week of medical appointments.
- Days Transported: Circle each day that transportation was provided within the designated week.

I. Recipient Verification of Medical Transportation

Transportation Provider Name: complete with provider's name.
Recipient's Name: complete with recipient's name.
Medicaid I.D.: complete with the recipient's 13-digit ID number.
Recipient's Address: complete with the recipient's complete address including ZIP Code.
Appointment Address: complete with the complete address of the appointment including ZIP Code.
Recipient's Signature and Date: the recipient must sign and date with that day's date. If the recipient signs with a mark, this mark must be witnessed by at least one person who can sign his/her own name.

II. Driver Verification

The driver of the vehicle should check the appropriate box indicating if transportation was provided to the medical facility OR from the medical facility then sign and date the form under the checked box.

III. Medical Service Provider Verification

The medical provider or his/her representative must complete this section indicating information about the appointment(s) and confirming that medical services were received.

If the recipient did not receive medical services for a scheduled appointment, an explanation is required.

An office stamp is accepted, but the medical provider or his/her representative must also sign and give his/her title and date.

The MT-3 may not be signed prior to the service being rendered.

The MT-3 should be returned to the transportation provider.