(NEMT Staff use only)

Claim #: _____

SOUTH DAKOTA MEDICAID
NON-EMERGENCY MEDICAL TRAVEL (NEMT)
CARE MANAGEMENT PROVIDER QUESTIONNAIRE

**** THIS FORM *MUST* BE SUBMITTED WITH SUPPORTING MEDICAL DOCUMENTATION ****

Our review of the NEMT reimbursement claim shows that the request is for travel to a Primary Care, Care Connect, or BabyReady provider who is not the closest available option to the recipient's home. NEMT can only reimburse travel to the nearest medical provider capable of delivering the necessary services. To continue processing this request, we need additional information explaining why services must be received from this provider instead of from a closer one.

***** TO BE FILLED OUT BY CARE MANAGEMENT PROVIDER *****

(This can be the recipient's Primary Care / Care Connect / BabyReady Provider)

Recipient's Name:	**Date of Birth:**
Recipient's Medicaid ID #:	

Reason for Receiving Services From This Provider:

☐ **Recipient has a medical condition that requires more advanced care or services than those available from local Primary Care, Care Connect, or BabyReady providers.** *Documentation Required: Supporting medical documentation explaining the need for advanced or specialized care must be attached and the two questions below must be completed.*

1. Does this patient require services or care that cannot be provided by any Primary Care, Care Connect, or BabyReady Provider within the patient's city of residence? ☐ *Yes* ☐ *No*
   If yes, briefly describe the medical reason or specialized care needed:

2. Is your clinic the closest provider from the recipient's city of residence that is capable of delivering these medically necessary services? ☐ Yes ☐ No
   If no, please list the closest provider and explain why the patient is being seen at your clinic instead:

☐ **Providers in the recipient's area are not accepting new patients.**
Documentation Required: A written statement from the closer Primary Care, Care Connect, or BabyReady provider(s) confirming they are not accepting new patients must be attached.

☐ **Personal preference.** Please explain: _____

☐ **Other (please specify)**: _____

Important Note: Please attach documentation supporting any medical condition or circumstance requiring the patient to receive services from a provider who is not the closest available. Failure to provide the necessary supporting documentation may delay the processing of the claim. If it is determined that a Primary Care, Care Connect, or BabyReady provider closer to the recipient's city of residence can provide the required services, reimbursement will only be issued for travel to the closest provider capable of providing the medically necessary services. However, if a Primary Care, Care Connect, or BabyReady provider is available within the recipient's city of residence and is able to provide the required services, program rules prohibit reimbursement for travel within the city.

Printed Name: _____

Signature: _____ **Date**: _____
(Care Management Provider: Primary Care / Care Connect / BabyReady Provider)

Please return this form by mail, email, or fax along with any necessary documentation, and if you have any questions, please contact our office at 1-866-403-1433 or email dss.ebtstateoffice@state.sd.us
Mailing Address: Department of Social Services, EBT and NEMT, 700 Governors Drive, Pierre, SD 57501
Local Phone Number: (605) 773-6527 I Fax Number: (605) 773-8461

If your claim was submitted online, please attach this form along with any necessary documentation to your online claim.