DSS NEMT-970 (01/2026)

(NEMT Staff use only)

Claim #: _____

SOUTH DAKOTA MEDICAID
NON-EMERGENCY MEDICAL TRAVEL (NEMT) REIMBURSEMENT FORM
- DAY TRIP - To Be Returned After Your Trip

If the recipient has multiple appointments, please print a SD Medicaid Non-Emergency Medical Travel Appointment Verification Form online at https://dss.sd.gov/medicaid/recipients/title19transportation.aspx and take it with you to the medical appointments.

***TO BE FILLED OUT BY MEDICAL PROVIDER ***

MEDICAL PROVIDER INFORMATION All fields MUST be completed

Appointment		**Please complete Admission/Discharge Date/Time for Hospital Stay only.**			
Date:	Time:	Admission Date:	Time:	Discharged Date:	Time:
Is this appointment at an outreach clinic? ☐ Yes ☐ No		Billing NPI:		Service NPI:	
Medical Facility Name:		Phone Number:		Ext:	
Address:		**For Pharmacy, Durable Medical Equipment, or Optical Supply:**			
Doctor's Name:		☐ No delivery available ☐ First fill of a new prescription ☐ Equipment fitting/adjustment			

Purpose of Visit (must be specific):

Is this a Medicaid covered service? ☐ Yes ☐ No

Is there a referral on file from the recipient's Care Management Provider? ☐ Yes ☐ No
(Care Management Provider: This can be the recipient's Primary Care, Care Connect, or BabyReady Provider.)

If travel was out of state, is there an Out of State Prior Authorization in place for the dates above? ☐ Yes ☐ No

Signature: _____ **Date**: _____
(Medical Provider: Doctor, Nurse, Receptionist or Pharmacist)

TO BE FILLED OUT BY RECIPIENT, PARENT OR GUARDIAN

TRIP INFORMATION All fields MUST be completed.

Departure Date (mm/dd/yyyy):	Return Date (mm/dd/yyyy):
Is the recipient currently Inpatient? ☐ Yes ☐ No	Is this a continuation for an ongoing trip? ☐ Yes ☐ No

RECIPIENT INFORMATION All fields MUST be completed**.**

Recipient Name:	Phone Number:
Medicaid Number:	Date of Birth (mm/dd/yyyy):
Recipient Mailing Address:	

If more than one recipient traveled and had a medical appointment during this trip, please list them in the following spaces

Recipient Name:	Phone Number:
Medicaid Number:	Date of Birth (mm/dd/yyyy):
Recipient Mailing Address:	
Recipient Name:	Phone Number:
Medicaid Number:	Date of Birth (mm/dd/yyyy):
Recipient Mailing Address:	

If there are more than three recipients who traveled and had a medical appointment during this trip, please provide details on a separate paper

TRAVEL POINTS All fields MUST be completed. List all stop(s) necessary to pick-up/drop-off a recipient(s). (Do not include stops for food, gas, etc.)

Are you requesting mileage reimbursement? ☐ Yes ☐ No

Does this trip include stops in more than one city? ☐ Yes ☐ No

Due to medical necessity, did you use a driver from outside your city of residence to transport you to or from your medical appointment? ☐ Yes ☐ No If yes (medical documentation required), list your driver's city of residence: _____

Departure Information Starting Location should reflect recipient's city of residence, and Ending Location is the city where the appointment was completed.

Starting Location (City, State):	Ending Location (City, State):

Mode of Travel: ☐ Air/Ground Ambulance ☐ Bus ☐ IHS Van ☐ Personal Vehicle ☐ Shriner's Van ☐ Transit Provider ☐ Other_____

Return Information Starting Location is the city where the appointment was completed, and Ending Location is the recipient's city of residence.

Starting Location (City, State):	Ending Location (City, State):

Mode of Travel: ☐ Air/Ground Ambulance ☐ Bus ☐ IHS Van ☐ Personal Vehicle ☐ Shriner's Van ☐ Transit Provider ☐ Other_____

Do you have miscellaneous expenses to report? ☐ Yes ☐ No
If yes, Expense Type: ☐ Public Transportation ☐ Parking Fees ☐ Luggage Fees ☐ Other: _____ Amount: $_____

Continue to the next page

TRAVEL ASSISTANCE All fields MUST be completed.

Did you received financial assistance from another source for this medical trip? ☐ Yes ☐ No
*Examples include (but are not limited to): Check/Cash, Gas Vouchers, Meal Passes

Name of Organization:	Phone #:

Mailing Address:

Type of Assistance: ☐ Cash ☐ Meals ☐ Transported Recipient ☐ Other: (please specify) _____

Amount of Assistance Received: $ _____

PAYMENT PROVIDER *(Individual who is to receive reimbursement for the travel)* All fields MUST be completed.
If you do not have a provider number for the individual who is to receive reimbursement for the travel, please have them enroll with NEMT at https://dss.sd.gov/nemt or have them complete the NEMT Payment Authorization Form, available at your local DSS office or online at https://dss.sd.gov/medicaid/recipients/title19transportation.aspx#forms.

Provider Number:
(The NEMT Provider Number is located at the top left-hand corner of the Paid Claim Statement.)

Provider First Name:	Provider Last Name:

Provider Mailing Address:

Provider City:	Provider State:	Provider Zip:

FINAL SUBMISSION Please include any additional supporting documentation to process your claim. Gas and meal receipts are not required.

I attest that the individual receiving mileage reimbursement and/or the individual driver for this medical trip possessed a valid driver's license during the dates traveled and that the individual receiving mileage reimbursement and/or the induvial driver for this medical trip is not excluded from participation in any federal health care program or is not listed on the exclusion list of the Department of Health and Human Services Office of Inspector General (https://exclusions.oig.hhs.gov/).
NOTE: This statement is excluded if recipient was transported by an entity/organization.

I understand that I will be reimbursed only to the closest provider capable of providing the necessary services. I certify that the information is correct to the best of my knowledge and any attached receipts represent eligible expenses. I understand that there are penalties for fraudulently submitting claims and misrepresenting receipts for reimbursement.

I am related to the individual(s) in the recipient section.

Please select one of the following:

☐ Recipient (Self) ☐ Parent ☐ Guardian *(Court ordered guardianship papers must be submitted to or on file with NEMT.)*

PRINTED NAME: _____

SIGNATURE: _____ **DATE**: _____

Please return this form by mail, email or fax along with any necessary documentation or receipts to:

Department of Social Services
EBT and NEMT
700 Governors Drive
Pierre, SD 57501

Local Phone Number: (605) 773-6527
Toll Free Number: 866-403-1433
Fax Number: (605) 773-8461
Email: dss.ebtstateoffice@state.sd.us

Claims may also be submitted through our online portal at https://dss.sd.gov/nemt

QUESTIONS? Please contact our office by calling our toll-free number at 1-866-403-1433 or by sending an email to dss.ebtstateoffice@state.sd.us.

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