DSS NEMT-973 (01/2026)

(For NEMT Staff use only)
Claim #: _____

SOUTH DAKOTA MEDICAID
NON-EMERGENCY MEDICAL TRAVEL (NEMT) APPOINTMENT VERIFICATION FORM

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 or make copies of this form and take it with you to the medical appointments.

MEDICAL PROVIDER INFORMATION All fields must be completed. Complete each section per appointment.

TO BE FILLED OUT BY MEDICAL PROVIDER

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

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:		Servicing 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 this date of service? ☐ Yes ☐ No

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

TO BE FILLED OUT BY MEDICAL PROVIDER

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

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:		Servicing 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			

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