

## WISCONSIN MEDICAID SPECIALIZED MEDICAL VEHICLE TRANSPORTATION TRIP TICKET / MEDICAL CARE VERIFICATION COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible members.

Members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but not be limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and members is confidential and is used for purposes directly related to Medicaid administration, such as determining eligibility of the applicant, processing prior authorization requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Provision of the required information requested on this form is mandatory for each trip. However, the use of an exact version of the form is voluntary and providers may develop their own form as long as it includes all of the required information on this form. Elements labeled "conditional" must be included if applicable to the trip. Information identified as "optional" is retained at the provider's discretion.

For further information about specialized medical vehicle (SMV) documentation, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

### INSTRUCTIONS

Type or print clearly. Wisconsin Medicaid requires a completed Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification form for each transport.

### SECTION I — PROVIDER INFORMATION

**Element 1 — Specialized Medical Vehicle Company (Required)**

Enter the name of the company by which the SMV is owned.

**Element 2 — Wisconsin Medicaid Provider Number (Eight Digits) (Required)**

Enter the billing provider's eight-digit Medicaid provider number.

**Element 3 — Date of Trip (MM/DD/YYYY) (Required)**

Enter the date on which the trip was made.

**Element 4 — Name — Driver (Last, First, Middle Initial) (Required)**

Enter one of the following:

- The driver's last name, first name, and middle initial. The middle initial is optional.
- The locally assigned unique identifier for the driver. The unique identifier is acceptable only if the identifier is documented in the provider's file with a cross-reference to the driver's full name. (Including the driver's middle initial in the cross-reference is optional.)

**Element 5 — SIGNATURE — Driver (Required)**

The driver is required to sign this element. The month, day, and year the form is signed must also be entered in the element in MM/DD/YY format.

**Element 6 — Vehicle Identification or License Plate Number (Required)**

Enter one of the following:

- Vehicle identification number (VIN).
- License plate number.
- Locally assigned number (e.g., fleet number). Wisconsin Medicaid requires that the locally assigned number be cross-referenced with either the VIN or license plate number and be documented in the provider's files.

**Element 7 — Name — Second Attendant (Last, First, Middle Initial) (Conditional)**

If applicable, enter the last name and first name of the second attendant present in the SMV during the trip. The middle initial is optional.

**Element 8 — Prescription for Second Attendant? (Conditional)**

Check "Yes" or "No."

## SECTION II — MEMBER INFORMATION

**Element 9 — Name — Member (Last, First, Middle Initial) (Required)**

Enter the last name, first name, and middle initial of the member. The middle initial is optional.

**Element 10 — Member Medicaid Identification Number (Optional)**

Enter the member's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

**Element 11 — Wheelchair or Scooter? (Required)**

Check "Yes" or "No."

**Element 12 — Cot or Stretcher? (Required)**

Check "Yes" or "No."

## SECTION III — ORIGINATING TRIP

**Element 13 — Address — Dispatch Location (Number, Street, City, State, and ZIP Code) — Unloaded Mileage (Conditional)**

Enter the complete address of the dispatch location. The ZIP code is optional.

**Element 14 — Odometer Readings — Unloaded Mileage (Conditional)**

Record the exact odometer reading at the dispatch location (start) and at the first pick-up location (end).

**Element 15 — Total Odometer Reading — Unloaded Mileage (Optional)**

Enter the total odometer reading.

**Element 16 — Address — Pick-Up Point (Name of Facility, Number, Street, City, State, and ZIP Code) (Required)**

Enter the name or type of facility and complete address of the facility at which the member was picked up. If the member was picked up at a private residence, enter "home" and the complete address of the residence. The ZIP code is optional.

**Element 17 — Odometer Reading — Trip Start (Required)**

Record the exact odometer reading at the start of the trip.

**Element 18 — Time — Trip Start (Required)**

Record the trip start time.

**Element 19 — Address — Drop-Off Point (Name of Facility, Number, Street, City, State, and ZIP Code) (Required)**

Enter the name and complete address of the facility at which the SMV dropped off the member. If the member was dropped off at a private residence, enter "home" and the complete address of the residence. The ZIP code is optional.

**Element 20 — Odometer Reading — Trip End (Required)**

Record the exact odometer reading at the member's drop-off location.

**Element 21 — Time — Trip End (Required)**

Record the trip end time.

**Element 22 — Waiting Time — Start (Conditional)**

Enter the time at which the SMV began waiting for the member.

**Element 23 — Waiting Time — End (Conditional)**

Enter the time at which the SMV stopped waiting for the member.

**Element 24 — More Than One Medicaid Member in Vehicle? (Required)**

Check "Yes" or "No."

**Element 25 — Name — Primary Rider (Conditional)**

Record the name of the individual for whom the standard base rate and mileage will be billed. This field is necessary if the trip includes more than one member (multiple rider trip). Record the primary rider's full name. The middle initial is optional.

**Element 26 — Total Odometer Reading (Optional)**

Enter the total odometer reading.

**SECTION IV — RETURN TRIP (Complete this section *only* if information in Sections I and II applies.)**

Section IV of the form should be completed *only* if the provider and member information for the return trip is the same as the information in Sections I and II. If the provider or member information is different, complete a new trip ticket.

**Element 27 — Address — Dispatch Location (Number, Street, City, State, and ZIP Code) — Unloaded Mileage (Conditional)**

Enter complete address of dispatch location. The ZIP code is optional.

**Element 28 — Odometer Readings — Unloaded Mileage (Conditional)**

Record the exact odometer reading at the dispatch location (start) and at the first pick-up location (end).

**Element 29 — Total Odometer Reading — Unloaded Mileage (Optional)**

Enter the total odometer reading.

**Element 30 — Address — Pick-Up Point (Name of Facility, Number, Street, City, State, and ZIP Code) (Conditional)**

This element is only required if this address is different than the drop-off address entered in Element 19. Enter the name or type of facility and complete address of the facility at which the member was picked up. The ZIP code is optional.

**Element 31 — Odometer Reading — Trip Start (Required)**

Record the exact odometer reading at the start of the trip.

**Element 32 — Time — Trip Start (Required)**

Record the trip start time.

**Element 33 — Address — Drop-Off Point (Name of Facility, Number, Street, City, State, ZIP Code) (Required)**

Enter the name and complete address of the facility at which the SMV dropped off the member. If the member was dropped off at a private residence, enter "home" and the complete address of the residence. The ZIP code is optional.

**Element 34 — Odometer Reading — Trip End (Required)**

Record the exact odometer reading at the member's drop-off location.

**Element 35 — Time — Trip End (Required)**

Enter the trip end time.

**Element 36 — More Than One Medicaid Member in Vehicle? (Required)**

Check "Yes" or "No."

**Element 37 — Name — Primary Rider (Conditional)**

Record the name of the individual for whom the standard base rate and mileage will be billed. This field is necessary if the trip includes more than one member (multiple rider trip). Record the primary rider's full name. The middle initial is optional.

**Element 38 — Total Odometer Reading (Optional)**

Enter the total odometer reading.

**SECTION V — VERIFICATION OF MEDICAID-COVERED MEDICAL CARE (OPTIONAL)**

Specialized medical vehicle providers are strongly encouraged to obtain verification of the medical nature of the trip for the purpose of a future audit by obtaining a signature from the medical service provider or his or her authorized representative.

**Element 39 — Name (Printed) — Person Verifying Medicaid-Covered Service**

Enter the name of the person who is verifying the Medicaid-covered service.

**Element 40 — Position Title — Person Verifying Medicaid-Covered Service**

Enter the position title of the person who is verifying the Medicaid-covered service.

**Element 41 — SIGNATURE — Person Verifying Medicaid-Covered Service**

Enter the signature of the person who is verifying the Medicaid-covered service.

**Element 42 — Date Signed — Person Verifying Medicaid-Covered Service**

Enter the date on which the person who is verifying the Medicaid-covered service signed the Specialized Medical Vehicle Transportation Trip Ticket/Medical Care Verification.