Michigan Department of Community Health

MEDICAL TRANSPORTATION STATEMENT - CHRONIC ONGOING TREATMENT

Document Number

- Use only **ONE** medical provider and **ONE** transporter per form.
- See **Page 2** for Instructions, Copy Distribution, PA 431 and Non-Discrimination Information.

SECTION I - DHS Specialist Completes:

DHS Specialist Name		Phone No. ( )			Authorized Rate Standard ☐ Special ☐		Patient/ Beneficiary Name	Beneficiary ID No.
DHS Case Number	Prog. Code	CO #	DIST #	SEC	UNIT	DHS SPEC	Address (No. & Street, City, State, ZIP Code)	

SECTION II - Medical Provider Completes:

Medical Provider's Name (MD, DO, DDS)	NPI Number	Address (No., Street, Bldg., Suite, etc.)	Provider's Phone No. ( )
Chronic, ongoing illness? (This usually means monthly ongoing care, but may include less than monthly care.) ☐ YES ☐ NO	Is overnight stay required? ☐ YES ☐ NO	City, State, ZIP Code	
Does someone need to accompany the patient to the medical appointment? ☐ YES → ☐ NO	If YES, Who & Why	Does patient need special transportation? ☐ YES → ☐ NO	Type (Van w/ wheelchair lift, etc.)

SECTION III - Transportation Provider Completes:

Transportation Provider's Name (Last, First)	Soc. Sec. No. or ID No.	Type of Transportation	Other Expenses (Parking Receipts, etc.)
Transportation Provider's Complete Address (No. & Street, City, State, ZIP Code)			Phone No. ( )

SECTION IV - Transportation Record:

APPOINTMENT DATE	ROUND TRIP MILEAGE	ATTENDANT FEE	APPOINTMENT DATE	ROUND TRIP MILEAGE	ATTENDANT FEE
1.			8.		
2.			9.		
3.			10.		
4.			11.		
5.			12.		
6.			13.		
7.			**TOTALS**		**$**

MEDICAL PROVIDER: I certify that I am a Medicaid enrolled provider and that I provided a medical service on the date(s) listed above.	Medical Provider Signature	Date
TRANSPORTER: I certify that I provided Medical Transportation Service on the date(s) listed above.	Transporter's Signature	Date
BENEFICIARY: I certify that I received Medical Transportation Service on the date(s) listed above.	Beneficiary's Signature	Date

SECTION V - Local DHS Specialist & Manager Complete:

A) Total Number of Miles **X** Appropriate rate in the BAM 825.	$	D) Greater of Line A or $1.80	$	DHS Specialist's Signature / Date
B) Special Rate (DHS-54A Received)	$	E) Other Expenses	$	DHS Manager's Signature / Date
C) Total of Lines A + B	$	F) Total Authorized: Special Rate = C + E; All Other = D + E	$	

SECTION VI - Local DHS Accounting Use Only:

Audited and Approved by:		Date	Doc. Type	Intf. Type	PDT	Bank ID No.	DMI
Appr. Yr.	Index	PCA	Agency Object Code			Amount $	
NIGP Code	MAIN/LOAAS Doc. No.	Check No. & Date	LOAAS Account No.				

MSA-4674A (10/09) Previous editions are obsolete.

Instructions for MSA-4674A

(Medical Transportation Statement - Chronic Ongoing Treatment)

GENERAL INSTRUCTIONS:

- **Use one form per month for each medical provider or transporter.**
- Use this form to show multiple trips made in a calendar month to the same medical provider (e.g., kidney dialysis treatment).
- This form must be returned to the local Michigan Department of Human Services within **90 days** of a given medical appointment date to receive payment for medical transportation.

COMPLETION INSTRUCTIONS:

SECTION I:

- The DHS Specialist completes this section.

SECTION II:

- The medical provider completes this section. (**Only one medical provider per form**.)

SECTION III:

- The transportation provider completes this section.
- Use only **ONE** transporter per form.
- Leave this section BLANK if the Beneficiary drives themselves OR if the Beneficiary wishes to receive the transportation payment directly.

SECTION IV - Transportation Record:

Medical Provider:

- Enter the **dates** of appointments for the whole calendar month.
- **Sign below** the individual date lines **after** all of the dates for the month have been entered to verify that each individual medical appointment did occur.

Transporter:

- The transporter enters the following for each appointment / visit: **round trip mileage** and the **attendant fee** if medically authorized.
- **Sign below** the individual date lines **after** all of the dates for the month have been entered to verify that transportation services were provided for EACH individual medical appointment.
- If SECTION III was **completed**, then only **that transporter** may sign in this section.

Patient / Beneficiary:

- **Sign below** the individual date lines **after** all of the dates for the month have been entered. This verifies that the Beneficiary kept each medical appointment and transportation services were provided.

SECTION V:

- The DHS Specialist calculates the transportation payment and signs their name.
- The DHS Manager reviews the entire form and signs their name approving the payment.

SECTION VI:

- The local DHS Accounting Unit completes this section.

COPY DISTRIBUTION:

Original:
- Mail or give this copy to the **Beneficiary** for completion by the Beneficiary, medical provider and the transporter.
- **Return to DHS Specialist** for completion. Forward to the local DHS Accounting Unit for payment processing.

Copy 1:
- Local DHS Case File copy

Copy 2:
- Give this copy to the Beneficiary and/or Transporter.

AUTHORITY: COMPLETION:	Title XIX of the Social Security Act Is Voluntary but required if payment from applicable programs is sought.	The Department of Community Health is an equal opportunity employer, services and programs provider.