MEDICAL TRANSPORTATION STATEMENT

Michigan Department of Health and Human Services

Case Name:
Case Number:
Date:
MDHHS Office:
Co: District: Section: Unit: Worker:
Specialist / ID: /
Phone:
Fax:
Individual ID:

If you do not understand this, call an MDHHS office in your area. MDHHS employees are prohibited by law from providing legal advice.
Si Ud. no entiende esto, llame a su oficina local del MDHHS. La ley prohíbe a los empleados de MDHHS proporcionar asesoría legal.
إذا واجهت صعوبة في فهم هذا الطلب، فأتصل بمكتب MDHHS الموجود في منطقتك. يحرّم القانون على موظفي MDHHS إعطاء النصيحة القانونية.

ENTER ADDRESSEE NAME
ENTER ADDRESSEE CARE OF
ENTER ADDRESSEE PO BOX OR STREET
ENTER ADDRESSEE CITY/STATE/ZIP

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

AUTHORITY: Title XIX of the Social Security Act.

COMPLETION: Is voluntary but required if payment from applicable programs is sought.

SIGMA Doc Code	SIGMA Doc Unit	SIGMA Doc ID

☐ One-time appointment ☐ On-going appointments

SECTION I - MDHHS Specialist Completes Only **ONE** medical provider and **ONE** transporter per form.

Beneficiary Name	Beneficiary Street Address	Apt. No.	City	State	Zip Code

Phone No.	Medicaid ID No.	Level of Care Code	TOA

Directions to the House

Special Instructions (Disabled, wheelchair, car seats, etc.)

Medical Provider Name	NPI No.	Medical Provider Street Address	Suite	Phone No.

City	State	ZIP Code

SECTION II - Transportation Provider

Transportation Provider Name				Soc. Sec. No. or TIN No.
Provider Street Address	**City**	**State**	**Zip Code**	**Phone No.**

SECTION III - Transportation Record (Provider / Transporter / Beneficiary Complete):

Appointment Date	Appointment Time	Departure Date and Time	Return Date and Time	Round Trip Miles	Attendant Initials	Medical Provider's Signature
TOTAL					I certify that I provided attendant service on the date(s) above.	I certify that I am a Medicaid enrolled provider and that I provided a medical service on the appointment date(s) above.

Beneficiary Signature	Date

Transporter Signature I certify that I provided the above service(s) and did not receive any other payment for this transportation. I am not aware that the passenger received any other payment for this transport. Any third party payment received but not indicated on this form must be reported to the Michigan Medicaid Program.	Date

Case Name	Case Number	Specialist

SECTION IV - Local MDHHS Specialist & Manager Complete

A)___ Miles X $____ (Appropriate mile-age rate)	$	D) Lodging	$	G) Total Auth (Lines A through F)	$	
B) Lift/Medivan Base Rate	$	E) Meals	$	MDHHS Specialist's Signature		Date
C) Fees and Tolls	$	F) Attendant(s)	$	MDHHS Manager's Signature		Date
Is the transportation provider CHAMPS enrolled? Yes ☐ No ☐ Not Applicable ☐						

SECTION V - Local MDHHS Office Use Only

Audited and Approved by:				Date
Budget Fiscal Year	Unit	Accounting Template	Department Object	Amount **$**

Instructions for MSA-4674 (Medical Transportation Statement)

- Use this form for 5 or less trips made in a month. Use 1 medical provider per form and 1 transportation provider per form.
- This form must be returned to the MDHHS local office within **90 calendar days** from the last date of service to authorize payment for medical transportation.

SECTION I:
- The MDHHS Specialist completes this section.

SECTION II:
- The transportation provider completes this section.
- Leave this section BLANK if the beneficiary drives themselves OR if the beneficiary wishes to receive the transportation payment directly.

SECTION III - Transportation Record:

Transporter:
- Enter the following for each appointment / visit: date, departure time, return time, number of miles traveled (round trip) and the attendant initials, if medically necessary.
- If SECTION III was completed, then only that transporter may sign at the bottom of this section.
- By signing this form, I certify that I provided the stated service(s) and did not receive any other payment for this transportation. I am not aware that the passenger received any other payment for this transport. Any third party payment received but not indicated on this form must be reported to the Michigan Medicaid Program.

Medical Provider (or their designee):
- Confirm the date(s) and time(s) of appointment(s) and sign your name to verify that the medical visit did occur.

Beneficiary:
- Sign the form to certify you received the transportation on the dates identified.

SECTION IV:
- The MDHHS Specialist calculates the transportation payment and signs their name and dates.
- The MDHHS Manager reviews the entire form and signs their name and dates, approving the payment.
- The local office must then submit this form to the appropriate MDHHS Accounting Service Center within 10 business days of receipt of the form.
- Transportation providers must be CHAMPS enrolled to receive mileage reimbursement from Medicaid for medical transportation services.

SECTION V:
- The local MDHHS office 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 MDHHS Specialist** for completion. Forward to the local MDHHS Accounting Unit for payment processing.

Copy 1: - Local MDHHS Case File copy.

Copy 2: - Give this copy to the Transporter Provider.