MEDICAID TRANSPORTATION
VERIFICATION OF RECEIPT OF MEDICAID COVERED SERVICE

TO: Medicaid Enrolled Provider

From: ___________________________ County Department of Social Services

Note: The County has the authority to administer the Medicaid program for the North Carolina Department of Health and Human Services Division of Medical Assistance pursuant to N.C.G.S. 108A-25 and rules adopted by the State of North Carolina.

When transportation assistance is provided to a Medicaid recipient, for audit purposes, it is necessary to document that the individual received a Medicaid covered service from a Medicaid-enrolled provider on the date of transport. Please complete the following:

This is to certify that ____

(Medicaid recipient's name/Medicaid ID Number)

visited this office or facility on ________________ and received a Medicaid covered service.

(date)

Name of Medicaid provider/facility: ____

Name of individual completing form (please print) ___________________________________

Phone number of person completing form ________________________

Signature of person completing form: ____

DHB-5118A (03/2022)