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: ____

DMA-5118A (New 1-15)

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