

**WISCONSIN MEDICAID  
 SPECIALIZED MEDICAL VEHICLE  
 TRANSPORTATION TRIP TICKET / MEDICAL CARE VERIFICATION**

**Instructions:** Type or print clearly. Refer to the Specialized Medical Vehicle Transportation Trip Ticket / Medical Care Verification Completion Instructions, HCF 1050A, for information on completing this form.

**SECTION I — PROVIDER INFORMATION**

1. Name — Specialized Medical Vehicle Company		2. Wisconsin Medicaid Provider Number (Eight Digits)	3. Date of Trip (MM/DD/YYYY)
4. Name — Driver (Last, First, Middle Initial)		5. <b>SIGNATURE</b> — Driver	
6. Vehicle Identification or License Plate Number	7. Name — Second Attendant (Last, First, Middle Initial)	8. Prescription for Second Attendant? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**SECTION II — RECIPIENT INFORMATION**

9. Name — Recipient (Last, First, Middle Initial)	10. Recipient Medicaid Identification Number	11. Wheelchair or Scooter? <input type="checkbox"/> Yes <input type="checkbox"/> No	12. Cot or Stretcher? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	--	--	---

**SECTION III — ORIGINATING TRIP**

13. Address — Dispatch Location (Number, Street, City, State, and ZIP Code) Unloaded Mileage		14. Odometer Readings — Unloaded Mileage _____ Start _____ End	15. Total Odometer Reading — Unloaded Mileage
16. Address — Pick-Up Point (Name of Facility, Number, Street, City, State, and ZIP Code)		17. Odometer Reading — Trip Start	18. Time — Trip Start <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
19. Address — Drop-Off Point (Name of Facility, Number, Street, City, State, and ZIP Code)		20. Odometer Reading — Trip End	21. Time — Trip End <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
22. Waiting Time — Start <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	23. Waiting Time — End <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	24. More Than One Medicaid Recipient in Vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	25. Name — Primary Rider
			26. Total Odometer Reading

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

27. Address — Dispatch Location (Number, Street, City, State, and ZIP Code) Unloaded Mileage		28. Odometer Readings — Unloaded Mileage _____ Start _____ End	29. Total Odometer Reading — Unloaded Mileage
30. Address — Pick-Up Point (Name of Facility, Number, Street, City, State, and ZIP Code)		31. Odometer Reading — Trip Start	32. Time — Trip Start <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
33. Address — Drop-Off Point (Name of Facility, Number, Street, City, State, and ZIP Code)		34. Odometer Reading — Trip End	35. Time — Trip End <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
36. More Than One Medicaid Recipient in Vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	37. Name — Primary Rider		38. Total Odometer Reading

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

39. Name (Printed) — Person Verifying Medicaid Covered Service	40. Position Title — Person Verifying Medicaid Covered Service
41. <b>SIGNATURE</b> — Person Verifying Medicaid Covered Service	42. Date Signed — Person Verifying Medicaid Covered Service