DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-01050 (07/08)

STATE OF WISCONSIN
DHS 107.23, Wis. Admin. Code

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, F-01050A, 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. **SIGNATURE** — Driver	

6. Vehicle Identification or License Plate Number	7. Name — Second Attendant (Last, First, Middle Initial)	8. Prescription for Second Attendant? ☐ Yes ☐ No

SECTION II — MEMBER INFORMATION

9. Name — Member (Last, First, Middle Initial)	10. Member Medicaid Identification Number	11. Wheelchair or Scooter? ☐ Yes ☐ No	12. Cot or Stretcher? ☐ Yes ☐ 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 ☐ a.m. ☐ 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 ☐ a.m. ☐ p.m.

22. Waiting Time — Start ☐ a.m. ☐ p.m.	23. Waiting Time — End ☐ a.m. ☐ p.m.	24. More Than One Medicaid Member in Vehicle? ☐ Yes ☐ 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 g	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 ☐ a.m. ☐ 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 ☐ a.m. ☐ p.m.

36. More Than One Medicaid Member in Vehicle? ☐ Yes ☐ 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. **SIGNATURE** — Person Verifying Medicaid Covered Service	42. Date Signed — Person Verifying Medicaid Covered Service