South Central Ohio Job & Family Services
475 Western Avenue, Suite B
PO Box 469
Chillicothe, Ohio 45601

Medicaid Verification Form Must be Dated

Client Name:_____ **Date of visit/service** _____

MUST be completed by the Health Care Provider

The client must return this verification form before he/she can receive additional assistance in the transportation program.

Instructions:

1. State if this visit/service/item is reimbursable by Medicaid for the named client/date
2. Either stamp or include your address, telephone number and signature
3. Please return to the client at this visit

Is this visit/service/item reimbursable through Medicaid? Yes _____ No _____

_____
Health Care Provider Name and Address

_____ Telephone #: _____
Health Care Provider's Signature

To be completed by Client

I understand by my signature that I authorize the release of medical information to the South Central Ohio Department of Job and Family Services for verification of eligibility in the Non-Emergency Transportation Program.

Also, with my signature I am verifying that I did attend a **MEDICAID BILLABLE** appointment and received Non-Emergency transportation on the said date to and/or from the stated Medicaid Provider.

X_____
Client's Signature

To be completed by Transport Driver

I understand by my signature that I am verifying that I did transport the named client on the said date to and/or from the stated Medicaid Provider.

Driver's Signature: _____