DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01050 (04/2022)

STATE OF WISCONSIN
Wisconsin Admin. Code DHS 107.23

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	3. Date of Trip (MM/DD/CCYY)

4. Name — Driver (Last, First, MI)	5. **SIGNATURE** — Driver

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

SECTION II — MEMBER INFORMATION

9. Name — Member (Name, First, MI)	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)	14. Odometer Readings — Unloaded Mileage _____Start _____End	15. Total Odometer Reading — Unloaded Mileage

16. Address — Pickup 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	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