SOUTHWEST HEALTH & HUMAN SERVICES

ASSISTANCE WITH GETTING TO MEDICAL APPOINTMENTS-SUMMARY OF INFORMATION

FOR PRIOR AUTHORIZATION OR QUESTIONS please contact: Monday-Friday 8-4:30 MA 027 12 22

For the last name starting with A-K
Jane Mellenthin 507-532-4127
607 W Main St, Ste 100, Marshall, MN 56258

For the last names starting with L-Z
Jennifer Beek 507-532-1222
607 W Main St, Ste 100, Marshall, MN 56258

The SWHHS Health Care Access plan will pay for the least costly form of transportation to enable you to get to your medical appointments.

SUBMIT YOUR CLAIM AS SOON AS POSSIBLE. CLAIMS MUST BE RECEIVED IN OUR OFFICE WITHIN 2 CALENDAR MONTHS OF THE DATE OF SERVICE.
(EX: IF THE DATE OF SERVICE WAS JANUARY 10TH, THE CLAIM MUST BE RECEIVED BY MARCH 31ST.)

If you have your own vehicle and can drive, you must use it whenever possible.
If you are unable to drive or find someone to drive your vehicle, then you may call to request a ride to your medical appointment. A doctor's note will be required.
If you are enrolled in Blue Plus, call Blue Ride at 866.340.8648. They require 48 hour notice.
If you are enrolled in UCare, call Health Ride at 800.203.7225. They require 48 hour notice.
If you have MA and are not enrolled in the above programs, please call either
Jane Mellenthin or Jennifer Beek based on your last name to ask for medical transportation. See above for their contact information.
If you have MinnesotaCare, only children under 21 or pregnant women can receive rides or be reimbursed for transportation costs.

If you are unable to drive your vehicle, you must try to find someone who can drive your vehicle or who would drive you in their vehicle. If you drive your vehicle or have someone drive your vehicle for you, you will be reimbursed 22¢ per mile for the miles when the patient is in the vehicle. Mileage is reimbursed per trip, not per the number of people in the vehicle or the number of people who have appointments at the same location. Bus or cab fares will be reimbursed at the rate charged but you must provide original receipts. No reimbursement will be made if the mode of transportation or related travel expense is furnished at no cost to the recipient.

If you choose to get medical services (including emergency services) outside of a 30/60 mile radius from your home, you may have to pay for your own transportation costs. Prior authorization is required from SWHHS if you request reimbursement for overnight expenses including lodging or meals, unless it is an emergency. If you have an emergency, contact SWHHS right away after the emergency to make arrangements for reimbursement of allowable expenses.

For services received on or after 01/01/2020, if your doctor says that you must have primary medical care that you cannot get within 30 miles from your home or specialty medical care that you cannot get within 60 miles from your home, reimbursement must be authorized by SWHHS. SWHHS will require a statement from a local provider verifying why it is medically necessary to travel beyond a 30/60 mile radius. If the request is approved, you may get reimbursed for mileage, meals, lodging, and parking. Lodging is limited to $50 per night unless SWHHS has given prior authorization for a higher amount and service provider is 60 miles or more away in the most direct route from your home. If someone must go with you in order for you to get necessary medical care, that person could also be reimbursed for meals and lodging. A medical provider must verify that you need to have another person at the appointment.

You may also be eligible for reimbursement of transportation related expenses during the months you were found to be eligible before the date you applied (retroactive coverage). If you appeal an action on your Medical Assistance/MinnesotaCare case, you are eligible for transportation related expenses and, if necessary, child care costs while you are attending the appeal hearing. Prior authorization is not required for transportation related expenses for emergencies, retroactive eligibility, or appeal hearings.

PRESCRIPTIONS: Costs to pick up prescriptions will not be reimbursed if the prescriptions could have been delivered or mailed to you at no additional cost.

MEALS: **You must need to travel more than 60 miles one way in the most direct route from your home to the medical appointment to get reimbursed for meals.**
Meal receipts must be original and must show what food item was purchased. Overnight meals need to be authorized.
Breakfast: reasonable costs up to $5.50 maximum. Must be in transit to/from or at a medical appointment before 6 a.m.
Lunch: reasonable costs up to $6.50 maximum. Must be in transit to/from or at a medical appointment between 11 a.m. and 1 p.m.
Dinner: reasonable costs up to $8.00 maximum. Must be in transit to/from or at a medical appointment after 7 p.m. or overnight due to the appointment time.

If you need a list of dentists who accept Medical Assistance, call your county office. If you need help finding a dentist who accepts UCARE, call (800) 235-0564.

SEE OTHER SIDE FOR MORE INFORMATION

MEDICAL EXPENSE REIMBURSEMENT CLAIM

Claim Payable To:	Patient's Full Name:
Phone #:	Patient's Date of Birth:
Address for Payment:	Patient's PMI #:
City: State: Zip:	Patient's Case #:

Please complete form using black ink.
Submit this form to either Jane Mellenthin or Jennifer Beek based on your last name. See reverse side of form for their contact information.
I declare under the penalties of the law that the information on this claim is just and correct and no part has been paid. I authorize the medical provider(s) to release attendance information about all appointments listed on this claim. I agree and understand that my information may be shared for investigation of fraud.

Signature:	**Date:**

- **CLAIMS MUST BE RECEIVED IN OUR OFFICE WITHIN 2 CALENDAR MONTHS OF THE DATE OF SERVICE.** (Ex: If the date of service was January 10th, the claim must be received by March 31st.) Correctly completed claims will be paid within 30 days from the date we receive your form. Incomplete forms will be returned to you and this will delay reimbursement.
- The medical provider(s) must stamp or sign this form or another statement from the clinic or hospital verifying each appointment. An appointment reminder card is not acceptable proof.
- **Turn in one form per patient.** The original form AND signature is required, no copies will be accepted. Turn in your original itemized receipts (for meals, lodging, parking, bus or cab fares, etc.). Service providers are allowed to fax a signed and completed claim.
- If you have traveled outside of a 30 mile radius from your home for primary medical care or a 60 mile radius from your home for specialty medical care, we require a statement from a local medical provider verifying why it is medically necessary to travel beyond a 30/60 mile radius from your home.

Driver Information:
□ I drove myself or someone drove my vehicle. (22¢/mile)
□ I am the parent or guardian. (22¢/mile)
□ I am a friend, relative, neighbor, personal care assistant, or corporate foster care staff. (22¢/mile)
□ I am a licensed foster care provider. (current MHCP rate)
□ Other _____

Was someone else required to be with the patient at a medical appointment?
□No □Yes
Name: _____
Reason: _____
You must provide a statement from the doctor verifying the need for another person at the appointment, unless the patient is a minor child.

Date of Service	Appt. Time	Name of Doctor	Specialist Y/N	Clinic / Hospital Name & Location	Provider Signature or Stamp	A0090 rcp/fp-uc A0080/vol Total Miles with Patient in Car	Agency Use Only Mileage $	A0170 Parking	A0180 Lodging	A0190 Meals (see detailed information on reverse) Name of person who ate meal	Breakfast Max $5.50	Lunch Max $6.50	Dinner Max $8.00

AGENCY USE ONLY					
Mileage @ 22¢/mile		05-420-650-2260-6027	County of Service #:	Vendor #:	
Mileage/MHCP or Other Rate		05-420-650-2260-6028	Date Approved:	Approved By:	Employee #:
Parking/Lodging/Meals		05-420-650-0000-6027	MA Spenddown: $	Total To Be Paid: $	