MEDICAID RIDE VOUCHER

Please make sure everything is filled out and that you someone from the medical facility have signed below.

***This box must be filled out in full by the medical facility to validate appointment.**

Check ONE: _____ Non-Ambulatory or _____ Ambulatory
(Wheelchair Assist) (Walk-On)

Last Name: ______________________ First Name: _______________________
(Please Print) (Please Print)

DOB: ____________________ Medicaid ID #: __________________________

Date of Medical trip: _____________________________

Medical Facility: ________________________________

Reason for Medical Trip: __________________________

Physician or Staff Signature: ___________________________________
This signature is to verify that the person named above took a medical trip and if they were ambulatory or non-ambulatory at the time of the ride.

Print Physician's Name: _____________________

***This box must be filled out in full by the medical facility to validate appointment.**

Recipient Signature: ______________________ Date: __________________

I certify that the above information is complete and accurate to the best of my knowledge.

Driver Signature: _______________________ LR#_________BUS#_______

Start Miles______________________ End Miles_______________________
(If ride went outside Pierre/Ft. Pierre city limits.)

Please Note this is for Medicaid recipients only. This will not cover Medicare or any other private insurance.

River Cities Public Transit
1600 East Dakota Ave.
605-945-2360