Medicaid Transportation Exception Request Form

Name: ________________________________  Medicaid ID: ________________
Address: ________________________________  DOB: ____________________

Reason for the request (please check all that apply):

☐ Car is not insured (letter confirming insurance termination necessary), or
☐ Car does not run (note from certified mechanic on letterhead necessary), or
☐ No licensed drivers in the home, or
☐ No one in the home is able to drive due to medical reasons (please attach detailed medical explanation of member’s condition relating to this issue), or
☐ A family member is using the car for work purposes, and the member can’t take time off for the doctor appointment (completed employer form attached).

Car #1: Make___________ Model_____________ Year ______ Running? _______
Car #2: Make __________ Model __________ Year ______ Running? _______

Signed: _____________________________ Date: ________________

Fax completed form to:

DVHA Transportation Unit, 879-5919

DVHA Decision: Approved ☐  Expires On: ________________  Denied ☐
Authorized by: ___________________________ Date: ___________

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