Substance Use Disorder Treatment Services

Transportation Assistance Request

Alaska Medicaid covers medically necessary authorized transportation and accommodation services when travel is required to receive non-emergency services from an enrolled Alaskan Medicaid provider. Transportation services must be authorized by Alaska Medicaid prior to travel occurring. The Department of Health partners with HMS, the Medicaid Fiscal Agent, and Tribal Health Organizations to authorize transportation around the state in accordance with the Department's coverage criteria.

HMS partners with the Division of Behavioral Health (DBH) for transportation requests associated with substance use disorders. DBH utilizes this form to authorize the Substance Use Disorder (SUD) treatment services prior to HMS determining coverage of the transportation event.

Additional information can be found on the under Documentation tab at medicaidalaska.com, Arranging Patient Travel

REFERRAL AGENCY: the agency assisting the client by coordinating treatment and facilitating transportation to access medically necessary residential treatment, transition to continuing care, or return to the home community. This agency will have performed the assessment determining the medically necessary level of care. This agency submits the completed form with the signed Medicaid Consent for Release of Information to DBH via fax. This agency becomes the Receiving Agency when coordinating return transportation.

Agency:

Name/Title:

Address:

City: **State:** Alaska **Zip Code:**

Telephone Number: **Fax Number:**

RECEIVING AGENCY: the agency that agreed to admit the client to residential SUD services or aftercare. The admission date should be provided to the Referring Agency to include on the Transportation Assistance Request. *This agency becomes the Referring Agency when arranging return transportation.

Agency:

Name/Title:

Address:

City: **State:** Alaska **Zip Code:**

Telephone Number: **Fax Number:**

SECTION 1: Client information

Client Name: **DOB:**

Medicaid ID Number:

Address:

Date of most recent assessment: **ASAM level of care:**

DSM-5, ICD-10 Diagnostic Code(s):

Client priority categories: Required - Check all that apply

☐ No ☐ Pregnant ☐ IDU ☐ Women with Children ☐ OCS involvement.

Client is Alaska Native/ American Indian? Unknown

Yes **The Release of Confidential Information and HIPAA privacy notice signed by client and is on file.**

SECTION 2: Transportation information

Reason for Travel: Required - Check all that apply Date of Travel:

☐ Withdrawal Management ☐ Culturally Relevant Treatment

☐ No capacity in Community of Residence ☐Other:

Continuing Care has been arranged with:

Facility/Agency providing continuing care:

Explanation of treatment:

Admission Date:

If the transportation request is for discharge: Type of discharge is required

☐ Successfully Completed Program ☐ Left on own/Refused Treatment

☐ Removed from Program

Discharge Date:

*Required if returning home

What other methods of payment have been explored?

☐ Insurance ☐ Native Corporation ☐ Tribal ☐ Other:

AUTHORIZATION:

Authorized by (DBH Employee):

Printed Name

Signature: **Date:**

Clear Form Save a copy