



# *Personal Transportation Services*

*(Mileage, meals, and lodging  
coverage for Medicaid members)*

*Medicaid and Other Medical  
Assistance  
Programs*



*This publication supersedes all previous Personal Transportation Services (mileage, meals, and lodging coverage for Medicaid members). Published by the Department of Health and Human Services, July 2003.*

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# Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated.

## Claims Processing Unit

Claims  
P.O. Box 8000  
Helena, MT 59604

**Phone:**  
(800) 624-3958 In- and out-of-state  
(406) 442-1837 Helena

## Member Eligibility

**FaxBack**  
(800) 714-0075 (24 hours)  
**Automated Voice Response**  
(800) 714-0060 (24 hours)  
**Montana Access to Health Web Portal**  
<http://mtaccesstohealth.acs-shc.com/mt/general/home.do>  
**Medifax EDI**  
(800) 444-4336, X2072 (24 hours)

## Department of Public Health and Human Services (DPHHS)

When a trip is canceled or rescheduled, return any travel funds to this address:

Health Resources Division  
DPHHS  
P.O. Box 202951  
Helena, MT 59620-2951

## Passport Member HelpLine

Medicaid clients who have general Medicaid or Passport to Health questions may call the Member HelpLine:  
**(800) 362-8312**  
Passport to Health  
P.O. Box 254  
Helena, MT 59624-0254

## Passport Provider Information

Passport to Health  
P.O. Box 254  
Helena, MT 59624-0254

Medicaid Provider Help Line  
**Phone:**  
(800) 624-3958 In- and out-of-state

## Policy Questions

Jan Paulsen  
Medicaid Services Bureau  
1400 Broadway  
P.O. Box 202951  
Helena, MT 59620-2951  
**Phone:**  
(406) 444-4189 In- and out-of-state  
**Fax:**  
(406) 444-1861  
**E-mail:** [jpaulsen@mt.gov](mailto:jpaulsen@mt.gov)

## Prior Authorization

Mountain Pacific Quality Health (Medicaid Transportation Center) is the Department's contractor that reviews transportation requests and grants authorization.

**Phone:**  
**(800) 292-7114** In- and out- of-state  
**(406) 443-6100** Helena

**Fax:**  
**(800) 291-7791** In- and out-of-state  
**(406) 443-0684** Helena

Send written inquiries to:  
Medicaid Transportation Center  
Mountain-Pacific Quality Health  
P.O. Box 6488  
Helena, MT 59604-6488

<b>Key Websites</b>	
<b>Web Address</b>	<b>Information Available</b>
<b>EDI Gateway</b> <a href="http://www.acs-gcro.com/">http://www.acs-gcro.com/</a>	EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: <ul style="list-style-type: none"> <li>• EDI support</li> <li>• Enrollment</li> <li>• Manuals</li> <li>• Provider services</li> <li>• Software</li> </ul>
<b>Health Resources Division</b> <a href="http://www.dphhs.mt.gov/hrd/">http://www.dphhs.mt.gov/hrd/</a>	<ul style="list-style-type: none"> <li>• <b>Big Sky Rx:</b> Helps Medicare members pay for Medicare-approved prescription drug insurance premiums.</li> <li>• <b>Electronic Billing:</b> How to submit Medicaid claims electronically.</li> <li>• <b>Healthy Montana Kids:</b> Information on HMK. See website below.</li> <li>• <b>Medicaid Member</b> Medicaid services for adults and children.</li> <li>• <b>Medicaid Provider Information:</b> See Montana Access to Health (MATH) Web Portal and Provider Information Website below.</li> <li>• <b>Medicaid Fraud and Abuse Reporting:</b> Provides telephone numbers to call if you have concerns about Medicaid fraud or abuse.</li> <li>• <b>Montana Medicaid:</b></li> <li>• <b>Passport to Health:</b> Information and enrollment forms for the Passport to Health primary care case management program.</li> <li>• <b>Prescription Assistance Programs:</b> Summary of information on the programs designed to make prescription drugs more affordable.</li> <li>• <b>Team Care:</b> Information and enrollment information for the Team Care program.</li> </ul>
<b>Healthy Montana Kids (HMK)</b> <a href="http://www.hmk.mt.gov/">www.hmk.mt.gov/</a>	<ul style="list-style-type: none"> <li>• Information on Healthy Montana Kids (HMK)</li> </ul>
<b>Montana Access to Health (MATH) Web Portal</b> <a href="https://mtacesstohealth.acs-shc.com/mt/general/home.do">https://mtacesstohealth.acs-shc.com/mt/general/home.do</a>  <b>Provider Information Website</b> <a href="http://medicaidprovider.hhs.mt.gov/">http://medicaidprovider.hhs.mt.gov/</a>	<ul style="list-style-type: none"> <li>• Fee schedules</li> <li>• Forms</li> <li>• Frequently asked questions (FAQs)</li> <li>• HIPAA update</li> <li>• Key contacts</li> <li>• Links to other websites and more</li> <li>• Medicaid news</li> <li>• Newsletters</li> <li>• Provider enrollment</li> <li>• Provider manuals, notices and manual replacement pages</li> <li>• Remittance advice notices</li> <li>• Upcoming events</li> </ul>
<b>Secretary of State</b> <a href="http://www.sos.mt.gov">www.sos.mt.gov</a>  <b>Administrative Rules of Montana</b> <a href="http://www.mtrules.org/">http://www.mtrules.org/</a>	<ul style="list-style-type: none"> <li>• Administrative Rules of Montana (ARM)</li> </ul>
<b>Washington Publishing Company</b> <a href="http://www.wpc-edi.com">www.wpc-edi.com</a>	<ul style="list-style-type: none"> <li>• EDI education</li> <li>• HIPAA guides and other tools</li> </ul>

# Introduction

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## Overview

This manual tells Medicaid members how to get transportation assistance to and from medical appointments. The Montana Department of Public Health and Human Services (DPHHS) maintains the Medicaid Transportation Center. The Transportation Center evaluates and approves all trip requests.

## Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. This manual should be used with the Administrative Rules of Montana (ARM). Rule citations in the text are a reference tool; they are not a summary of the entire rule. In the event that a manual conflicts with a rule, the rule prevails. Links to rules are available on the Provider Information website (see *Key Contacts*). Paper copies of rules are available through the Secretary of State's office (see *Key Contacts*). In addition to the general Medicaid rules outlined in the *General Information for Providers* manual, the following rules and regulations are also applicable to the ambulance program:

- Code of Federal Regulations (CFR)
  - 42 CFR 431.53 Assurance of Transportation
  - 42 CFR 441.62 Transportation and Scheduling Assistance
- Administrative Rules of Montana (ARM)
  - ARM 37.86.2401--2605 Ambulance Services

## Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a prior authorization contractor or Provider Relations). The list of *Key Contacts* at the front of this manual has important phone numbers and addresses pertaining to this manual. The *Introduction* chapter in the *General Information for Providers* manual also has a list of contacts for specific program policy information. Medicaid manuals, notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information website (see *Key Websites*).

The Transportation Center reviews requests and grants approval for trips that meet requirements. All trips must be approved before traveling. For instructions on getting trips approved, see the *Passport* and *Prior Authorization* chapters in this manual. For questions about transportation or approval, contact the Transportation Center at (800) 292-7114 or (406) 443-6100. This manual and other information are available on the Provider Information website (see *Key Websites*). Use this manual with Administrative Rules of Montana (ARM), <http://www.mtrules.org>.



# Covered Services

## What Are Travel Assistance Benefits?

Travel assistance benefits are funds that help Medicaid members with transportation costs. These funds help members get to and from medical appointments. When the member meets certain requirements, he/she may get help with mileage, meals, and lodging. These benefits are for members who have Standard Medicaid coverage. The Transportation Center must approve all trips before the travel. The *Passport* and *Prior Authorization* chapters in this manual explain how to request transportation.

Transportation services are available for members with Standard Medicaid coverage. Transportation services are not available for members with the following coverage:

- Qualified Medicare Beneficiary (QMB). This member has a Medicaid ID card, but transportation is not covered for members who have “QMB Only” coverage.
- Specialized Low-Income Medicare Beneficiary Program (SLMB). This member is not issued a Medicaid ID card.
- Mental Health Services Plan (MHSP) and Healthy Montana Kids (HMK).

To verify member eligibility, refer to the Member Eligibility and Responsibilities chapter in the *General Information for Providers* manual.

When a member needs transportation, the member or a representative must contact the Transportation Center at 1-800-292-7114 or (406) 443-6100. The member can get paid only when the Transportation Center approves the trip. The *Passport* and *Prior Authorization* chapters in this manual explain how to request transportation. The member or the driver gets paid when the member returns from the trip. See the *Payment* chapter in this manual for more information on getting travel funds.

### ***Personal transportation***

Personal transportation is for members who do not have special transportation needs. The member travels in a personal vehicle driven by the member or a friend or relative. Personal transportation is covered when it is the least costly method of transportation. Member reimbursement is based on mileage. This manual covers personal transportation requirements.

### ***Specialized non-emergency transportation***



All requests for transportation must be authorized before the trip (see the *Passport* and *Prior Authorization* chapters in this manual).



A member's freedom of access to health care does not require Medicaid to provide financial assistance beyond the closest site or service or to cover the member's personal choice of health care.

Specialized non-emergency transportation is for members who are wheelchair-bound or must be transported by stretcher. Medicaid-enrolled providers supply this transportation. Members must get prior authorization for this transportation. Specialized non-emergency transportation providers should see the *Commercial and Specialized Non-Emergency Transportation* manual.



All members or their representatives, including adoptive and foster parents, must obtain authorization

### ***Commercial transportation***

Commercial transportation is for members who do not have special transportation requirements. This transportation is covered only when other, less costly means of transportation are not available. This transportation includes taxicab, bus, airplane, etc. Medicaid-enrolled providers supply this service. Members must get prior authorization for this transportation. The *Passport* and *Prior Authorization* chapters in this manual explain how to request transportation. Commercial transportation providers should see the *Commercial and Specialized Non-Emergency Transportation* manual.

## **Which Type of Transportation Would Be Approved?**

Approval is always based on the least expensive available means of transportation suitable to the member's medical needs. Members must get prior authorization for all transportation requests. The *Passport* and *Prior Authorization* chapters in this manual explains how to request transportation.

## **When Is Travel Assistance Covered? (ARM 37.86.2402)**

The Department provides financial assistance for a Medicaid member (and an attendant when required) when all of the following requirements are met:

- The Medicaid member obtains Medicaid-covered services.
- The medical services are determined medically necessary.
- The member selects the least expensive means of transportation suitable to his or her medical needs.
- No other financial resources are available.
- Other methods of transportation (such as city bus) are not available, or circumstances or disability prevent the use of such transportation.
- Applicable prior authorization and Passport to Health requirements are met. See the *Passport* and *Prior Authorization* chapters in this manual.

The mileage allowed per trip is based on the nearest facility, regardless of where the member chooses to receive health care.

### ***Nursing facility members***

Nursing facilities must provide non-emergency routine transportation (visits to physicians, pharmacy or other medical providers) when the destination is within 20 miles of the facility. Medicaid may provide financial assistance for transportation in one of the following circumstances:

- If a member is wheelchair-bound or requires transport by stretcher.
- If a member must travel farther than 20 miles to a Medicaid covered appointment.



Medicaid only covers transportation to the nearest Medicaid provider.

***Presumptive eligibility (pregnant women)***

Transportation help is available for uninsured pregnant women. The member must provide a copy of her eligibility determination letter until she receives her Medicaid ID card. Contact your local Office of Public Assistance for more information on presumptive eligibility.

***Deceased member***

Transportation is paid if a member dies on the way to or during treatment outside his/her community. The cost of returning a deceased person is not covered.

**What Services Are Covered?*****Mileage, meals, and lodging***

Members may receive financial assistance for mileage, meals, and lodging while receiving Medicaid covered medical care outside the member's community. Mileage is a set amount per mile for a Medicaid member to travel in a privately owned vehicle. Allowances for meals and lodging are also a set amount. The fee schedule on the Provider Information website (see *Key Websites*) lists payment amounts. Meal coverage begins on the member's second day. The Transportation Center must approve all travel assistance before the trip.

***Attendant***

Financial assistance is provided for one attendant to accompany a member for whom age or disability requires attendant services. Medicaid covers transportation, meals, and lodging for the attendant to travel to and from medical services outside the member's own community.

Once an adult member reaches the destination for medical services, coverage of the attendant will be whichever is lowest:

- The Medicaid allowed amount for transportation, meals, and lodging for the attendant's stay during the member's course of treatment
- The allowed amount for a second round trip (go home then return to take the member home)

Lowest cost comparisons are usually not applied when the member is a child. Attendant meals and lodging can be allowed for the child's entire stay if the attendant chooses to remain with the child throughout the course of treatment. The Transportation Center must approve attendant assistance before the trip. The *Passport* and *Prior Authorization* chapters in this manual explain how to request attendant services.

## What Is Not Covered? (ARM 37.86.2402)

- Meals and/or lodging are not covered for a round trip that can reasonably be made in one day.
- Payment for mileage is not available for local travel within the town or city where the member lives.
- Additional travel expenses such as parking costs, toll charges, gas, car maintenance, laundry, phone calls, etc. are not covered.
- Transportation assistance is not covered for members who have been determined retroactively eligible for Medicaid when the transport occurred before retroactive eligibility was determined.
- Medicaid does not cover services that are free to the member such as meals or lodging provided by a friend or relative.
- Medicaid does not cover transportation that is provided in a state or government vehicle.

### ***Other Programs***

Transportation expenses for Mental Health Services Plan (MHSP) and Healthy Montana Kids (HMK) are not covered.



# Passport to Health Program

## What Is Passport to Health? (ARM 37.86.5101–5120, ARM 37.86.5303, and ARM 37.86.5201–5206)

Passport to Health is the managed care program for Montana Medicaid and Healthy Montana Kids (HMK) *Plus* members. The four Passport programs encourage and support Medicaid and HMK *Plus* members and providers in establishing a medical home and in ensuring the appropriate use of Medicaid and HMK*Plus* services:

- Passport to Health Primary Care Case Management
- Team Care
- Nurse First Advice Line
- Health Improvement Program

Medicaid and HMK*Plus* members who are eligible for Passport must enroll in the program (about 70% of Montana Medicaid and HMK*Plus* members are eligible). Each enrollee has a designated Passport provider who is typically a physician, midlevel practitioner, or primary care clinic.

### ***Passport to Health Primary Care Case Management (ARM 37.86.5101–5120)***

The Passport provider provides primary care case management (PCCM) services to their members. This means he/she provides or coordinates the member's care and makes referrals to other Montana Medicaid and HMK *Plus* providers when necessary. Under Passport, Medicaid and HMK *Plus* members choose one primary care provider (PCP) and develop an ongoing relationship that provides a medical home. The medical home is a concept that encourages a strong doctor-patient relationship. An effective medical home is accessible, continuous, comprehensive, coordinated, and operates within the context of family and community.

With some exceptions (see *Services That Do Not Require Passport Provider Approval* in this chapter), all services to Passport members must be provided or approved by the member's Passport provider or Medicaid/HMK*Plus* will not reimburse for those services. The member's Passport provider is also referred to as the PCP.

### ***Team Care (ARM 37.86.5303)***

Team Care is designed to educate members to effectively access medical care. Members with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. Members enrolled in Team Care are also enrolled in Passport. Team Care follows the same Passport rules and guidelines for referrals, enrollment/disenrollment, prior authorization, and



Medicaid does not pay for services when prior authorization or Passport requirements are not met.



Different codes are issued for Passport approval and prior authorization, and both must be recorded on the claim form if appropriate.

billing processes. However, while Passport members can change providers without cause, as often as once a month, Team Care members are locked in to one provider and one pharmacy. Providers are encouraged to make a referral to the Team Care Program Officer if they feel one of their members is appropriate for the program. A Passport provider receives an enhanced case management fee of \$6 per member per month for Team Care members. When checking Medicaid or HMK*Plus* eligibility on the Montana Access to Health (MATH) web portal (see *Key Websites*), a Team Care member's provider and pharmacy will be listed. Write all Medicaid and HMK*Plus* prescriptions to the designated pharmacy.

### ***Nurse First Advice Line***

The Nurse First Advice Line at 1-800-330-7847 is a 24/7, toll-free, and confidential nurse triage line staffed by licensed registered nurses and is available to all Montana Medicaid, HMK, and HMK *Plus* members. There is no charge to members or providers. Members are encouraged to use the Nurse First Advice Line as their first resource when they are sick or hurt. Registered nurses are available 24/7 to triage members over the phone and recommend appropriate care. Health coaches are also available to answer general health or medication questions. Nurses do not diagnose or provide treatment. The Nurse First Advice Line will fax a triage report to the Passport PCP when one of their members calls to be triaged.

Passport providers are encouraged to provide education to their members regarding the appropriate use of the emergency department (ED), including using the Nurse First Advice Line before going to the ED.

### ***Health Improvement Program (ARM 37.86.5201–5206)***

The Health Improvement Program (HIP) is for Medicaid and HMK *Plus* members with chronic illnesses or risks of developing serious health conditions. HIP is operated statewide through a regional network of 14 community and tribal health centers. Medicaid and HMK *Plus* members eligible for the Passport program are enrolled and assigned to a health center for case management. Current Passport patients stay with their PCPs for primary care, but are eligible for case management services through HIP. Nurses and health coaches certified in professional chronic care will conduct health assessments; work with PCPs to develop care plans; educate members in self-management and prevention; provide pre- and post-hospital discharge planning; help with local resources; and remind members about scheduling needed screening and medical visits.

Medicaid uses predictive modeling software to identify chronically ill members. This software uses medical claims, pharmacy and demographic information to generate a risk score for each member. Although the software will provide a great deal of information for interventions, it will not identify members who have not received a diagnosis or generated claims. PCPs may also identify and recommend Passport members at high risk for chronic health con-

ditions that would benefit from case management from HIP using the [HIP referral form](#) on the Health Improvement Program page of the Provider Information website.

In practice, providers will most often encounter Medicaid and HMK *Plus* members who are enrolled in Passport. Specific services may also require prior authorization (PA) even if the member is a Passport enrollee. Passport referral and approval requirements and PA requirements are described below. Specific PA requirements can be found in the provider fee schedules.

## Role of the Passport Provider

- Maintain a written record of all referrals given and received for every Passport member treated.
- Provide primary and preventive care, health maintenance, treatment of illness and injury, and coordination of member's access to medically necessary specialty care by providing referrals and follow-up.
- Provide Well-Child checkups, EPSDT services, blood lead screenings and immunizations.
- Develop an ongoing relationship with Passport members for the purpose of providing continuity of care.
- Educate members about appropriate use of office visits, the ED, and urgent care clinics.
- Identify and refer members to the Team Care Program whose use of services is excessive and inappropriate with respect to medical need.
- Coordinate and collaborate with care managers in Medicaid HIP, including providing information regarding the needs of the member, reviewing and commenting on care plans prepared by care managers, and providing copies of medical records when requested.
- Provide coverage for needed services, consultation, and approval or denial of referrals during regular office hours.
- Provide 24-hour availability of information for seeking emergency services.
- Accept auto assignment of members when PCP has openings and the members meet the PCP-defined restrictions.
- Provide appropriate and HIPAA-compliant exchange of information among providers.
- Educate and assist members in finding self-referral services (e.g., family planning, mental health services, immunizations, and other services).
- Maintain a member medical record for each Passport member. Providers must transfer the member's medical record to a new primary care provider if requested in writing and authorized by the member.

### ***Providing Passport referral and authorization***

- Before referring a Passport member to another provider, verify that the provider accepts Medicaid.
- When referring a member to another provider, give that provider your Passport number.
- All referrals must be documented in the member's medical record or a telephone log. Documentation should not be submitted with the claim.
- Passport approval may be for a one-time visit, a time-specific period, or the duration of an illness or pregnancy, as determined by the Passport provider.

See the *Passport Referral and Approval* section on the next page for details.

### ***Member disenrollment***

A provider can ask to disenroll a Passport member for any reason including:

- The provider-member relationship is mutually unacceptable.
- The member fails to follow prescribed treatment (unless this lack of compliance is a symptom of the medical condition).
- The member is abusive.
- The member could be better treated by a different type of provider, and a referral process is not feasible.

Providers cannot terminate a provider-member relationship in mid-treatment. To disenroll a member, write to Passport to Health (see *Key Contacts*). A provider must continue to provide Passport management services to the member while the disenrollment process is being completed.

### ***Termination of Passport agreement***

To terminate a Passport agreement, notify Passport to Health (see *Key Contacts*) in writing at least 30 days before the date of termination. Termination is effective on the first day of the month following notice of termination, or the first day of the second month following notice of termination, whichever allows a 30-day time period to elapse.

### ***Utilization review***

Passport providers' utilization patterns are analyzed on a regular basis. When a provider's average rates for service utilization are consistently high or low, the provider may be asked to furnish information regarding unusual practice patterns.

### ***Caseload limits***

Passport providers may serve as few as one or as many as 1,000 Medicaid members. Group practices and clinics may serve up to 1,000 members for each full-time equivalent provider.

## Member Eligibility Verification

Member eligibility verification will indicate whether the member is enrolled in Passport. The member's Passport provider and phone number are also available, and whether the member has Standard Medicaid coverage. To check a member's eligibility, go to the MATH web portal (see *Key Websites*). Other methods of checking member eligibility can be found in the *Member Eligibility and Responsibilities* chapter of the *General Information for Providers* manual.

## Medicaid Services – Provider Requirements

To be covered by Medicaid, all services must be provided in accordance with the requirements listed in the *Provider Requirements* chapter of the *General Information for Providers* manual and in the *Covered Services* chapter of this manual. PA and Team Care requirements must also be followed.

## Passport Referral and Approval (ARM 37.86.5110)

If a member is enrolled in Passport, most services must be provided or approved by the member's Passport provider. While Passport referral and approval is needed for most medically-necessary services that the member's Passport provider does not provide there are some exceptions (see *Services That Do Not Require Passport Provider Approval* in the following section).

### ***Making a referral***

Referrals can be made to any other provider who accepts Montana Medicaid. Referrals can be verbal or in writing, and must be accompanied by the Passport provider's Passport approval number. Passport providers are required to document Passport referrals in the member's records or in a log book. Documentation should not be submitted with the claim. The Passport provider establishes the parameters of referrals, which may be for a one-time visit, a time-specific period, or the duration of an illness or pregnancy. An optional referral form is available at the Passport link on the Provider Information website (see *Key Websites*).

### ***Receiving a referral as the non-PCP***

The member's Passport provider must be contacted for approval for each visit unless another time parameter was established. It is best to get Passport approval in advance, in writing, and specific to services and dates. Using another provider's Passport number without approval is considered fraud. If a provider accepts a member as a Medicaid member and provides a service that requires Passport provider approval without the member's Passport provider's approval, Medicaid will deny the claim. If a provider tries unsuccessfully to get approval from the PCP, the provider cannot bill the member. The provider can bill the member if the member agreed to pay privately before services were rendered (ARM 37.85.406).

For details on when providers can bill Medicaid members, see the *Billing Procedures* chapter in the Medicaid billing manual for your provider type.

If a Passport provider refers a member to you, do not refer that member to someone else without the Passport provider's approval, or Medicaid will not cover the service.

### ***Passport approval and prior authorization (PA)***

Passport approval and PA are different, and both may be required for a service. PA refers to a list of services that require prior authorization through a Department contractor, Mountain-Pacific Quality Health. See the *Additional Medicaid Requirements for Passport Members* in your *Passport to Health Provider Handbook*, and the Medicaid billing manual for your specific provider type for more information on PA and Passport. The *Medicaid Covered Services* chapter in the *General Information for Providers* manual is an overview of services with PA and Passport indicators.

## **Services That Do Not Require Passport Provider Approval (ARM 37.86.5110)**

- Ambulance
- Anesthesiology
- Audiology
- Blood lead testing
- Dental
- Dialysis
- Durable medical equipment
- Emergency department
- Eye exams and eyeglasses
- Family planning
- Hearing exams and aids
- Home- and community-based services
- Home infusion therapy
- Hospice
- Hospital swing bed
- Immunizations
- Intermediate care facilities for the mentally retarded
- Laboratory tests
- Licensed clinical counseling
- Mental health case management

- Mental health services
- Nursing facilities
- Obstetrics
- Optometrists and ophthalmologists
- Personal assistance services in a member's home
- Pharmacy
- Podiatry
- Psychologists
- Residential treatment centers
- Social workers (licensed)
- Substance dependency treatment
- Targeted case management
- Therapeutic family care
- Transportation (commercial and specialized non-emergency)
- X-rays

### Passport and Emergency Services (ARM 37.86.5110)

Passport providers must provide **direction** to members in need of emergency care 24 hours each day, 7 days a week. For more information on direction, education, and suitable coverage for emergency care, see the *Passport to Health Provider Handbook*.

- **Emergency services provided in the ED.** Passport provider approval is not required for emergency services. Emergency medical services are those services required to treat and stabilize an emergency medical condition. Non-emergencies in the ED will not be reimbursed, except for the screening and evaluation fee and any appropriate imaging and diagnostic services that are part of the screening. For more information, see *Emergency Services* on the Provider Information website (see *Key Websites*) or in the Medicaid billing manual for your provider type.
- **Post stabilization and Passport.** Services for members admitted through an emergency room (identified by the presence of Revenue Code 45X or 65X on the claim) will be exempt from Passport requirements and from cost share requirements.

### Passport and Indian Health Services

Members who are eligible for both Indian Health Service (IHS) and Medicaid may choose IHS or another provider as their Passport provider. Members who are eligible for IHS do not need a referral from their Passport provider to obtain services from IHS. However, if IHS refers the member to a non-IHS provider, the Passport provider must provide the referral.

## Complaints and Grievances

Providers may call Provider Relations (see *Key Contacts*) to report a complaint that something inappropriate has taken place. A grievance is a written complaint and must be addressed to the Passport Program Officer (see *Key Contacts*). See the *Passport to Health Provider Handbook* for a full review of complaints, administrative reviews and fair hearings.

## Getting Questions Answered

The *Key Contacts* list provides important phone numbers and addresses. Provider and member help lines are available to answer almost any Passport or general Medicaid question. You may call Provider Relations to discuss any problems or questions regarding your Passport members, or to enroll as a Passport provider. You can keep up with changes and updates to the Passport program by reading the Passport provider newsletters and other information available on the Provider Information website (see *Key Websites*). For claims questions, call Provider Relations.

## Becoming a Passport Provider (ARM 37.86.5111–5112)

A primary care provider (PCP) can be a physician, primary care clinic, or mid-level practitioner (other than a certified registered nurse anesthetist) who provides primary care case management by agreement with the Department. The Department allows any provider who has primary care within his/her professional scope of practice to be a PCP. The Department does, however, recognize that certain specialties are more likely to practice primary care. The Department actively recruits these providers. Passport providers receive a primary case management fee of \$3.00 a month for each enrollee.

To enroll in Passport, Medicaid providers must complete and sign a Passport provider agreement. The Passport provider agreement and the *Passport to Health Provider Handbook* are available on the Provider Information website (see *Key Websites*). Providers may also call Provider Relations (see *Key Contacts*) for information on becoming a Passport provider and to get the Passport provider agreement.

### ***Solo Passport provider***

A solo Passport provider is enrolled in the program as an individual provider with one Passport number. The solo provider is listed as the member's Passport provider. The solo provider is responsible for managing his/her individual Passport caseload. For details on referral documentation, see *Passport Referral and Approval* in this section of the manual. Case management fees are paid to the individual provider under the solo provider's Passport number in addition to the fee-for-service reimbursement.

### ***Group Passport provider***

A group Passport provider is enrolled in the program as having one or more Medicaid providers practicing with one Passport number. The group name will be listed as the member's Passport provider and could be a private group clinic, rural health clinic (RHC), federally qualified health center (FQHC), or Indian Health Service (IHS). All participating providers sign the Passport agreement group signature page and are responsible for managing the caseload. As a group provider, members may visit any provider within the group practice without a Passport referral. Case management fees are paid as a group under the group Passport number in addition to the fee-for-service reimbursement.

## **Passport Tips**

- View the member's Medicaid eligibility verification at each visit by going to the MATH web portal on the Provider Information website (see *Key Websites*) or by using one of the other methods described in the *Member Eligibility and Responsibilities* chapter of the *General Information for Providers* manual.
- Do not bill for case management fees; they are paid automatically to the provider each month.
- If you are not your member's Passport PCP, include the Passport PCP's Passport approval number on the claim, or it will be denied.
- The same cost sharing, service limits, and provider payment rules apply to Passport and non-Passport Medicaid members and services.
- For claims questions, refer to the *Billing Procedures* chapter in this manual, or call Provider Relations (see *Key Contacts*).

## **Other Programs**

Members who are enrolled in the Mental Health Services Plan (MHSP) or Healthy Montana Kids (HMK) are not enrolled in Passport, so the Passport requirements in this chapter do not apply. However, prior authorization may be required for certain services. Refer to the mental health manual.

For more HMK information, contact Blue Cross and Blue Shield of Montana at 1-877-543-7669 (toll-free, follow menu) or 1-855-258-3498 (toll-free, direct). Additional HMK information is available on the HMK website (see *Key Websites*).



# Prior Authorization

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## What Is Prior Authorization? (ARM 37.86.2401 and 37.86.2402)

Prior authorization (PA) is the review and approval by the Department or the Department's contractor of the medical necessity and coverage of a service before delivery of the service. The Medicaid Transportation Center evaluates and authorizes members' trip requests (see *Key Contacts*).

The member must call in or fax all trip requests to the Transportation Center before the medical appointment. Call in requests as early as possible. The Transportation Center needs time to verify current eligibility, check Passport approval if necessary, consider the nearest appropriate medical provider, and determine the least expensive and most appropriate mode of travel. If advance notice is insufficient to allow these steps to be taken, the trip may not be covered.

## Requesting Authorization

To request prior authorization, the member must contact the Transportation Center with trip details. If a member is unable to communicate the need for transport, an authorized member representative such as facility personnel, a case manager or a family member may request authorization. To request transportation, follow these two steps:

1. Write down the required information about your trip. You may use the *Travel Request Form* located at the end of this chapter to record the required information, or simply write it down on paper. The following information is required for all transports:
  - Patient's name
  - Medicaid ID # (Social Security Number)
  - Date of appointment
  - Reason for transport (diagnosis)
  - Name of driver
  - Physician's full name, phone number, and address
  - Time of appointment
2. Contact the Medicaid Transportation Center. You may call or fax the required information. Transportation Center staff are available from 8:00 a.m. to 5:00 p.m. Monday through Friday. After hours, leave a detailed message on the voice mail (available around the clock).



All transportation requests should be called in as soon as the appointment is scheduled.

You may reach the Transportation Center at:

Medicaid Transportation Center  
Mountain-Pacific Quality Health  
P.O. Box 6488  
Helena, MT 59604-6488

**Phone:**  
**(800) 292-7114** In/out of state  
**(406) 443-6100** Helena

**Fax:**  
**(800) 291-7791** In/out of state  
**(406) 443-0684** Helena

The Transportation Center is required to follow all Department rules and regulations, and has no authority to make exceptions or waive rules.

When transportation requests are approved, the member will not receive notification unless he/she specifically requests it. Members are informed of adverse decisions in writing, as well as by phone whenever possible. Adverse decisions may include approval of reduced distance or denial of travel funds.

The transportation contractor has no authority to make exceptions or waive Department rules.

## Appeals

When trip requests are denied, members receive written denial notices from the Transportation Center. Denial notices contain instructions for appeals.

If the member disagrees with a denial or the amount of payment issued, he/she may submit a written appeal to the Transportation Center within 30 days of the denial notice. Written appeals must contain all details of the transportation request. The Transportation Center will then perform a second review.

If the request is approved after review and additional funds are to be released, the Transportation Center will notify the member or the member's authorized representative.

If the request remains denied, the Transportation Center will send the member a letter indicating a second review was conducted and the request remains denied. All denial notices contain instructions for requesting a fair hearing.

<b>Completing a Travel Request Form</b>	
<b>Field</b>	<b>Description</b>
Name of requester	Name of the member or the person who is requesting transportation for the member
Phone number	Phone number of the person requesting transportation for the member
Patient name	Medicaid member's full name
Medicaid ID number	Medicaid member's Medicaid ID number
Patient phone number	Medicaid member's phone number
Date of birth	Medicaid member's date of birth
Patient's mailing address	Medicaid member's mailing address
Street address	Medicaid member's street address
City, state, ZIP code	Medicaid member's city, state, and ZIP code
Dates of appointment	Date of member's appointment or procedure
Return date (if different)	Date member will return from appointment if different from appointment date (e.g., overnight stay)
Appointment time	Time for which the appointment is scheduled
Is this for multiple dates?	Does this cover multiple visits over several days?
Number of trips	Number of trips the member will be making
Reason for appointment	Purpose for the appointment (list services that will be provided)
Referred by	If the member's doctor referred the member to another physician or for tests, enter the name of the doctor who referred the member in this field.
Doctor's phone number	Phone number of referring doctor
Going to (name of doctor, facility, etc.)	Enter the name of the doctor and/or facility where this appointment will take place.
Dept.	Enter the department where appointment will take place (e.g., Radiology, CT, MRI).
Phone number	Phone number where appointment will take place
Extension/Name	Department's phone number extension (if applicable) and/or name of contact
Complete physical address	Street address of department where appointment will take place
Is this a round trip?	Will the member be making a round trip, or is travel one way?
Is an attendant required?	Is an attendant necessary due to age or disability?
Reason for attendant	State the specific reason that an attendant is needed for the trip.
Mode of transportation	Fill in the details regarding the transportation mode/source. Complete only one box.
Any special conditions or concerns?	Specify any unusual travel needs (e.g., needs oxygen on board, needs help transferring to wheelchair).
Comments	Include details about the trip such as if a second or third appointment will be completed during the trip. For additional appointments include where, when, purpose, etc.

## Travel Request Form

Name of requestor: \_\_\_\_\_ Phone # \_\_\_\_\_

Patient Name: \_\_\_\_\_ Medicaid ID#: \_\_\_\_\_

Patient phone number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's Mailing Address: \_\_\_\_\_ Street Address: \_\_\_\_\_

City, State Zip code: \_\_\_\_\_

Date(s) of Appointment: \_\_\_\_\_ Return Date (if different): \_\_\_\_\_

Appointment time(s): \_\_\_\_\_

Is this for multiple dates of service?  Yes  No      Number of trips: \_\_\_\_\_

Reason For Appointment: \_\_\_\_\_

Referred by: \_\_\_\_\_ Referring Doctor's Phone number: \_\_\_\_\_

Going to (Name of Dr, facility, etc): \_\_\_\_\_

Dept (ie Radiology, ER, etc.): \_\_\_\_\_

Phone #: \_\_\_\_\_ Extension/ Name: \_\_\_\_\_

Complete Physical Address of destination: \_\_\_\_\_

Is this a round-trip?  Yes  No

Is an attendant required?  Yes  No      Reason for an Attendent: \_\_\_\_\_

### Mode of transportation (complete only one box):

<input type="checkbox"/> <b>Patient driving</b> <input type="checkbox"/> <b>Other Driver (not patient)*</b>  *Name of Driver: _____  Complete Mailing address: _____ _____
---

<input type="checkbox"/> <b>Taxi</b> <input type="checkbox"/> <b>Wheelchair van</b>  Name of Provider: _____ Pick-up time: _____  <b>***Note:</b> taxi dispatches require 24 hours notice whenever possible
--

<input type="checkbox"/> <b>Other Transportation</b> Please explain mode and need: _____ _____ _____
---

Any special conditions or concerns: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

<b>For MPQHF use only:</b> Ref: _____      Clerk: _____ <input type="checkbox"/> <b>Approved</b> <input type="checkbox"/> <b>Denied</b> <input type="checkbox"/> <b>Pended</b> Faxed back response: _____      Comments: _____
--

# How Payment Is Calculated

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## Transportation and Lodging Payment (ARM 37.86.2405)

Payment may be made for mileage, meals and lodging for the member and a required attendant. Mileage is measured directly to and from the Medicaid member's home community and the community of destination. Meals and lodging are not covered when a trip can be reasonably made in one day. Payment for meals begins the second day of the member's stay. Receipts are required for lodging allowance.

### ***Personal vehicle mileage***

Personal vehicle mileage is paid at a set rate per mile. The Transportation Center determines total miles per trip based on the number of miles from the member's community to the community with the closest site of service.

### ***Meals***

Meal receipts are not required for payment. Payment for meals is posted on the fee schedule on the Provider Information website (see *Key Websites*).

### ***Lodging***

When lodging is necessary, financial assistance is provided. **Lodging receipts are required** and can be mailed or faxed to the Transportation Center (see *Key Contacts*). Most hotels/motels are willing to fax receipts. Payment for lodging is posted on the fee schedule on the Provider Information website (see *Key Websites*).

The Transportation Center issues a check for travel funds as soon as it can be confirmed that the trip was taken and necessary medical services were received. Only one mileage payment check will be issued per trip regardless of the number of individuals transported.

## Canceled Travel Plans

If the member's travel plans are canceled or rescheduled, all travel funds must be returned to the Department (see *Key Contacts*). Funds that are not returned to the Department will be recovered by garnishment of tax refunds.



Checks for less than \$5.00 will not be issued.



# Definitions and Acronyms

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**This section contains definitions, abbreviations, and acronyms used in this manual.**

## **Administrative Rules of Montana (ARM)**

The rules published by the executive departments and agencies of the state government.

## **Allowed Amount**

The maximum amount reimbursed to a provider for a health care service as determined by Medicaid, MHSP, HMK, or another payer. Other cost factors, (such as cost sharing, third party liability (TPL), or incurment) are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

## **Attendant**

A person who accompanies the Medicaid member to Medicaid covered medical appointments. The Medicaid member's age or disability determine the necessity of attendant services. Attendant services must be prior authorized.

## **Authorization**

An official approval for action taken for, or on behalf of, a Medicaid member. This approval is only valid if the member is eligible on the date of service.

## **Commercial Transportation**

Travel services provided by air or ground commercial carrier, taxicab, or bus necessary for a Medicaid member to receive medical care.

## **DPHHS, State Agency**

The Montana Department of Public Health and Human Services (DPHHS or the Department) is the designated State Agency that administers the Medicaid program. The Department's legal

authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

## **Emergency Services**

Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

## **Health Improvement Program**

A service provided under the Passport to Health program for members who have one or more chronic health conditions. Care management focuses on helping members improve their health outcomes through education, help with social services, and coordination with the member's medical providers.

## **Healthy Montana Kids (HMK)**

HMK offers low-cost or free health insurance for low-income children younger than 19. Children must be uninsured U.S. citizens or qualified aliens, Montana residents who are not eligible for Medicaid. DPHHS administers the program and purchases health insurance from Blue Cross and Blue Shield of Montana (BCBSMT). Benefits for dental services and

eyeglasses are provided by DPHHS through the same contractor (ACS) that handles Medicaid provider relations and claims processing.

### **Medicaid/HMK Plus**

A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad Federal guidelines.

### **Medically Necessary**

A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the member. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member requesting the service. For the purpose of this definition, *course of treatment* may include mere observation or, when appropriate, no treatment at all.

### **Member**

An individual enrolled in a Department medical assistance program.

### **Mileage**

The distance traveled by a Medicaid member in a privately owned vehicle from once community to another in order to receive Medicaid-covered medical care. This service must be prior authorized.

### **Nurse First Advice Line**

The Nurse First Advice Line is a toll-free, confidential number members may call any time any day for advice from a registered nurse about injuries, diseases, health care or medications.

### **Passport Referral Number**

This is a 7-digit number assigned to Passport providers. When a Passport provider refers a member to another provider for services, this number is given to the other provider and is required when processing the claim.

### **Passport to Health**

The Medicaid medical home program where the member selects a primary care provider who manages the member's health care needs.

### **Personal Transportation**

Transportation provided in a privately owned vehicle by the Medicaid member or the member's friend or relative.

### **Prior Authorization (PA)**

The approval process required before certain services or supplies are paid by Medicaid. PA must be obtained before providing the service or supply.

### **Provider or Provider of Service**

An institution, agency, or person having a signed agreement with the Department to furnish medical care, goods and/or services to members, and eligible to receive payment from the Department.

### **Retroactive Eligibility**

When a member is determined to be eligible for Medicaid effective prior to the current date.

### **Specialized Non-Emergency Transportation**

Transportation services supplied by a provider with a class B public service commission license. The provide has a vehicle specially equipped to transport persons with disabilities such as a wheelchair van or stretcher van.

### **Standard Medicaid**

Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information for Providers* manual, *Appendix A: Medicaid Covered Services*.

### **Team Care**

A restricted services program that is part of Passport to Health. Restricted services programs are designed to assist members in making better health care decisions so that they can avoid overutilizing health services. Team Care members are joined by a team assembled to assist them in accessing health care. The team consists of the member, the PCP, a pharmacist, the Department, the Department's quality improvement organization, and the Nurse Family Advice Line. The team may also include a community-based care manager from the Department's Health Improvement Program



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