



**DIVISION OF BEHAVIORAL HEALTH (DBH)
MEDICAL ASSISTANCE PROGRAMS
REQUEST FOR SUBSTANCE USE DISORDER SUPPORTED TRAVEL ASSISTANCE
(MEDICAID)**

1. REFERRAL AGENCY

The Referring Agency is the agency that has the first contact with the client and who determines that the client requires a higher level of care than available locally. The Referring Agency must submit to the Receiving Agency a copy of a Release of Information for both communication with the Receiving Agency and for the Travel Request.

Name/Title _____

Agency _____

Address _____

Telephone _____ Fax _____

2. RECEIVING AGENCY

The Receiving Agency concurs that the client is in need of a higher level of care and agrees to admit the client. The travel request form and Release must be submitted to DBH by the Receiving Agency

Name/Title _____

Agency _____ ASAM Level _____

Address _____

Telephone _____ Fax _____

Release of Confidential Information and HIPAA privacy notice signed by client and on file

1. Client Name _____ Address _____ DOB _____
Medicaid ID# _____

2. ASAM Patient Placement Criteria Third Edition _____

3. DSM-5 or ICD 10 Diagnostic Code(s) _____

4. Reason for travel check all that apply): Detoxification Intermediate Care Culturally Relevant Treatment
 No Capacity in Community of Residence Return home/discharge Other _____
 Continuing Care following treatment: Arranged with _____
(indicate facility or agency) _____

(Please explain treatment)

5. Is the client from one of the priority categories? (check all that apply)
 Pregnant IDU Women with Children

6. Admission Date _____ Discharge Date (if returning home) _____

7. Cost of One-Way Ticket: _____ Date of Travel: _____

8. Name/Title of Escort _____ Cost of RT Ticket _____
Reason for escort _____ Approved: Yes No

9. What other methods of payment have been explored? (Medicaid, Insurance, Native Corps., Tribal) _____

Authorized by DBH Behavioral Health Specialist _____ Date _____