

# Wyoming Medicaid – Travel Request Form

## Section 1 – Member Information

Member Name: _____		Member ID: _____	
Preferred Contact:	Phone _____	Email _____	N/A _____
Full Physical Address:			
Address _____		City _____	State _____ Zip _____
Full Mailing Address (if different from physical address):			
Address _____		City _____	State _____ Zip _____
Additional Person of Contact (if no personal email or phone):			
Name _____		Phone _____	Email: _____

## Section 2 – Travel Information

Date of Travel (leaving/returning):		Appointment Date/Time:	
Leaving _____	Returning _____	Date _____	Time _____
Name of Doctor/Office Visiting: _____		Doctor's Address: _____	
Address _____		City _____	State _____ Zip _____

## Section 3 – Member 20 years or younger (if Member is 21 years and older, please see section 4)

Please answer all statements below:

1. Member is age 20 or younger? \_\_\_ Yes \_\_\_ No
2. Total mileage will be over 400 miles round trip **OR** 150 miles round trip with multiple appointments on consecutive days? \_\_\_ Yes \_\_\_ No
3. Member is inpatient at the facility? \_\_\_ Yes \_\_\_ No

If Yes, enter Facility Name: \_\_\_\_\_

Are you staying overnight for the Member's appointment(s)? ___ Yes ___ No	Lodging for appointment: ___ Ronald McDonald House of Aurora    ___ Ronald McDonald House of Billings ___ Brent's Place    ___ Hotel    ___ Other – must include Name: _____
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## Section 4 – Transportation Details

Please indicate travel type:

\_\_\_ Personal car    \_\_\_ Driven by family/friend

\_\_\_ Taxi/Bus/Shuttle    Indicate Taxi/Bus/Shuttle Provider Name (if applicable): \_\_\_\_\_

## Section 5 – Payee Information (Person Receiving Payment for Travel)

Full Name (First, Middle, Last): _____	SSN: _____	Relationship to Member: _____	Have you received travel reimbursement before? <span style="float: right;">___ Yes ___ No</span>
Full Mailing Address (if different from Member's mailing address):			
Address _____		City _____	State _____ Zip _____

## Section 6 – Additional Information

Are you receiving any assistance from sources other than Medicaid? ___ Yes ___ No	If Yes, please explain: _____
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Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

WYBMS-Wyoming Medicaid Travel Request Form



## Completing the Wyoming Medicaid – Travel Request Form

### Section 1

- Please fill out all information fully. To be approved for reimbursement, full verification of identification is required.
- If you haven't requested travel assistance before, please complete the included W-9 Form, and return with travel request form.
- If you do not have an active phone or email for contact, please include the number of a friend, family member, or guardian who we would be able to leave a message with for you (in case of errors on claim form, questions about dates or provider, etc.)

### Section 2

- If there are multiple travel dates, please include a sheet of paper indicating the extra dates in question with your form, along with the appropriate appointment dates and times.
- Member is required to be active with Wyoming Medicaid on date(s) of service.
- Doctor you are seeing is required to be enrolled and active with Wyoming Medicaid on the date(s) of service.
- If you are requesting emergency funds or airline travel assistance, please call the Customer Service Center at (855) 294-2127 and select the option for travel assistance. These requests cannot be processed with this request form.

### Sections 3-4

- Please note that only Members under the age of 21 will be eligible for lodging assistance.
- If staying with facility enrolled with Medicaid, facility must be active on date of service.