Beltrami County Health and Human Services
616 America Avenue NW, Suite 330 • Bemidji, MN 56601
Phone (218) 333-8023
Fax (218) 333-4131

VERIFICATION OF MEDICAL SERVICE

Medical appointments attended

This form must be completed by Health Care Provider Personnel.

Patient Name: _____ has been seen for a scheduled medical appointment(s) on the following:

Date:	**Time:**	**Initial each visit:**

_____
Doctor, Nurse, or Receptionist (signature required)

_____
Name and Location of Medical Facility
(Facility stamp or letterhead)

HealthCare Access for Services Request Form
Reimbursement

NOTICE TO CLIENTS:
This form must be completed, your verification of attendance and any receipts for incurred expenses attached for reimbursement

Today's Date: _____

Name of Patient: _____ **Patient Date of Birth:** _____

Date/s of services: (Please list begin and end dates): _____

Phone number where you can be reached: _____

Reimbursement Requested for: (Please check all that apply and add dates for lodging and meals)

Lodging: _____ **Meals:** _____ **Mileage:** _____
Date(s) **Date(s)**

Other: _____ **License Plate#** _____
Specify

EMERGENCY CASES:
Was the patient sent by emergency services to a hospital or other facility? Y____ N____

If YES, and patient was transferred out of town you must attach transfer papers and/or a referral from the local medical provider.

Must complete:

Reimbursement to: _____

Mailing Address: _____

_____

All information is needed to process reimbursement check.

I completed this form and I verify the appointment verification attached is true:

Signature of person requesting reimbursement: _____

HealthCare Access for Services Request Form
UPCOMING APPOINTMENTS

Appointments out of the local service area must be prior authorized to be reimbursed. Please turn in requests Five (5) business days PRIOR to date of appointment.

NOTICE TO CLIENTS:

Complete the information below. Attach a copy of the medical appointment and referral for the medical appointment out of the area

Today's Date:_____

Name of Patient: _____**Patient Date of Birth:** _____

Address: _____

Appointment Date: _____ **Time:** _____

Location of Appointment:

_____

Phone number where you can be reached: _____

******This must be a valid phone number! We must be able to reach you to discuss your request. In some cases you may not be eligible for everything you have requested. ******

Services Requested: (Please check all that apply and add dates for lodging and meals)

Lodging:_____ **Meals:**_____ **Mileage:**_____ **Volunteer Driver**____
Dates **Dates** **local bus service** ____

Name of adult accompanying child: _____

Signature of person requesting services: _____

Revised: 11/28/17

Please fax completed and signed statement to Leticia C. @ 218-333-4131 c/o Beltrami County Human Services. If you have questions, call Leticia C. at 218-333-8023

HEALTH CARE PROVIDERS STATEMENT OF MEDICAL NECESSITY
This statement must be completed and signed by a health care provider employed by the facility where the patient is **locally** being treated and has knowledge of the medical necessity for services and the patient's medical/mental health.

Patient _____ DOB: _____

Appointment at: _____ Address: _____

Please initial all that apply and the requested information, if applicable:

_____ This patient cannot get this type of necessary medical care in the local service area and _____ is the **nearest available** medical facility to provide the medical service.

_____ This patient must have an adult attendant/family member because patient is not able to travel independently or make critical medical decisions on his/her own due to a severe physical or mental condition.

_____ This patient's written treatment plan requires the involvement of the following person/people: _____

_____

_____

Transportation: _____

_____ This patient is unable to travel the day of his/her appointment, so must have overnight lodging because of the following **medical reason**: _____

_____

_____ This patient is unable to use Public Transit (bus or van) due to severe medical or emotional condition.

_____ This patient is unable to drive his/her vehicle to medical appointments due to:

_____

Health Care Provider's signature **Date**

_____

Name of Hospital or Clinic **Phone number**

Revised 11/28/17

Beltrami County Health and Human Services will monitor medication treatment services. Please fax completed and signed statement to Leticia C. @ 218-333-4131 c/o Beltrami County Human Services. If you have questions, call Leticia C. at 218-333-8023

HEALTH CARE PROVIDERS STATEMENT OF MEDICAL NECESSITY

This statement must be completed and signed by the health care provider employed by __ _____ where the patient is being treated and has knowledge of the medical necessity for services received by the patient along with knowledge of the patient's medical/mental health.

Patient _____ DOB: _____

Appointment at _____

Please complete all the requested information, if applicable:

_____This patient is currently under my care at: _____

_____

Please Print: Counselor/Case Manager Name and Phone number

Date of last Assessment: _____; Assessment done by: _____

(Annual assessment review)

Name of County or Tribe who made the referral and/or is managing this patient:

_____

_____ This patient requires continued medication treatment services.

Comments:

_____

_____

_____

Health Care Provider's signature **Date**

_____

Phone number

Revised 11/28/17