

Medicaid Vehicle Exception Request Form

Please fax or mail this application and necessary documentation to DVHA at above contact info

Member Name: _____ Medicaid ID #: _____

Address: _____ DOB: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Reason for the request (please check all that apply):

- ☐ Vehicle is not insured (letter confirming insurance termination necessary), or
- ☐ Vehicle does not run (note from certified mechanic on letterhead necessary), or
- ☐ No licensed drivers in the home, or
- ☐ No one in the home is able to drive due to medical reasons (note from medical professional outlining member's conditions relating to this issue), or
- ☐ A family member is using the car for work purposes, and the member can't take time off for the doctor appointment (completed employer form attached).

Vehicle 1: Make _____ Model _____ Year _____ Running? _____

Vehicle 2: Make _____ Model _____ Year _____ Running? _____

Vehicle 3: Make _____ Model _____ Year _____ Running? _____

Signed: _____ Date: _____

DVHA USE ONLY - Authorized By: _____ Date: _____

Approved ☐ Exp. Date: _____

Denied ☐