



CONNECTING PEOPLE WITH CARE

**REQUEST FOR REIMBURSEMENT OF MEDICAL TRANSPORTATION**

Reimbursement will only be considered if you call CTS **2 business days before** your non-urgent medical appointment and are pre-approved to participate in the Medical Transportation Reimbursement Program. Reimbursement will not be provided if approval was not received before your appointment. Medical appointments must be covered by Medicaid.

**Call CTS at 1-877-671-6291**

**MEMBER AND TRIP INFORMATION:**

Member's NH Medicaid ID #: \_\_\_\_\_ Date: \_\_\_\_\_

Member's Name: \_\_\_\_\_

Member's Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If travel by car: Transporter's driver's license #: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Tolls: Amount Paid: \$ \_\_\_\_\_ Parking: Amount Paid: \$ \_\_\_\_\_ (Provide receipt(s) showing amount paid)

If travel by public transportation: Bus \_\_\_\_\_ Train \_\_\_\_\_ (Provide receipt(s) showing amount paid)

Member's Signature: \_\_\_\_\_

*I certify that the information on this form is true, accurate and complete. I understand that payment of this claim may be from Federal and State funds and that any false claims, statements, documents or concealment may be prosecuted under applicable Federal and State Laws. I agree to accept CTS' transportation payment as payment in full.*

**Your doctor or medical provider must complete and sign the form below:**

**TO BE COMPLETED BY YOUR PHYSICIAN / MEDICAID PROVIDER ONLY - PLEASE PRINT:**

\_\_\_\_\_  
Physician / Medical Provider / Clinic Name / Pharmacy Name

Street Address City State Zip Code

Dates of Covered Medical Services
_____
_____
_____
_____
_____
_____
_____

I attest that the member named above visited my office/clinic/ pharmacy for non-emergent medical appointment(s) on the date(s) as noted.
By: _____ / _____ Physician/Medicaid Provider Signature / Date
_____ National Provider Identifier (N.P.I.)

The reimbursement rate is \$0.41 per mile. Only one claim may be submitted per trip, even if there is more than one passenger (He-W 574.06(e)). Forms must be sent **within 30 calendar days** from the date of your last appointment.

Send form to: **Coordinated Transportation Solutions, 35 Nutmeg Drive, Suite 120, Trumbull, CT 06611** (mail), **provider@ctstransit.com** (e-mail), or **1-203-375-0516** (fax). For payment questions call 1-877-671-6291.

**\*\*\*\* CONFIDENTIALITY NOTICE \*\*\*\***

This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled, unless otherwise required by state law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of these documents.