nh healthy families

CTS Est. 1997 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. Urgent requests (ex: Urgent Care Clinic) can be scheduled the same day as the appointment. Reimbursement will not be provided if approval is not received before your appointment. Medical appointments must be covered by Medicaid.

Call CTS at 1-877-671-6291 to schedule your appointment

MEMBER AND TRIP INFORMATION:

Member's Name: _____ Member's NH Medicaid ID #: _____

Member's Address: _____

If travel by car: Driver's Name _____ Driver's License #: _____

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: _____ Date:_____

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.

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

_____

Physician / Medical Provider / Clinic Name / Pharmacy Name

_____

Street Address City State Zip Code

Circle the month of your appointment (circle only 1 month)

Jan	Feb	Mar	Apr	May	June
July	Aug	Sept	Oct	Nov	Dec

Circle the date(s) of your appointment

1	2	3	4	5	6
7	8	9	10	11	12
13	14	15	16	17	18
19	20	21	22	23	24
25	26	27	28	29	30
31					

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 form may be submitted per appointment type even if there is more than one passenger (He-W 574.06(e)). Forms must be sent within 30 calendar days from the last date of service listed on this form.

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.