FORM NHEP256A
PUBLIC/PRIVATE TRANSPORTATION CARRIER PROVIDER INVOICE

Please print all information. **Please read the instructions on the back** before you begin.

Provider Information	NHEP Address
Name **Address** **City** **State** **Zip Code**	

-----Fold

ETS Service Request Number: | | | | | | | | |

Recipient's Name (First, Last)	Recipient's ID Number (RID)

DATES OF SERVICE (MM/DD/YY): ALL dates must be within the SAME MONTH!				Please check only one appropriate box.
Begin Date of Transportation Service	/ /	**End Date of Transportation Service**	/ /	☐ **MULTI-RIDE SERVICE** ☐ **MONTHLY SERVICE** ☐ **OTHER SERVICE**

In order for payment to be made, the transportation provider must be an enrolled provider with the Department of Health and Human Services. The information requested below was provided with DHHS enrollment approval.

Resource # | | | | | | | | |

TRANSPORTATION PROVIDER PAYMENT CERTIFICATION	Total Cost of Transportation Service for This Recipient
I request payment for the amount I have indicated. I have not listed extra costs or fees for transportation. I certify that this information is true and accurate. I understand that this bill may be selected for review and verification.	**$**

Transportation Provider's Signature **Date**

Distribution: White - Data Management Unit Canary - Transportation Provider DFA SR 10-07 (D)

Instructions for Public/Private Transportation Carrier Provider Invoice

This Form serves as an invoice with which enrolled transportation providers may bill the Department of Health and Human Services (DHHS) for services provided to the recipient. Invoices must be submitted within **90 days** of the end date of service in order to receive payment. Payment may be made for multiple, weekly, or monthly transportation services but must include only services provided in **one calendar month**. **Use a separate invoice for each type of service, even if providing multiple services to the same recipient, *and for each calendar month billed*.** Be sure that the invoice is complete and legible. **NOTE: NHEP participants must receive prior approval for these services. The NHEP participant should provide a copy of the ETS Approval Letter to the provider prior to service provision.**

PROVIDER INFORMATION

Enter the provider's name, address, including street name and number or PO Box, town/city name, state, and zip code. **Incorrect, incomplete, or illegible addresses may cause delays in payment.**

ETS SERVICE REQUEST NUMBER

Enter the 4 to 8-digit ETS Service Request Number indicated on the ETS Service Approval Letter.

RECIPIENT'S NAME and RECIPIENT'S ID NUMBER (RID)

Enter the first and last name of the recipient for whom the transportation service is being billed. Enter the 10-digit recipient identification number (RID) assigned to the recipient by DHHS.

DATES OF SERVICE (MM/DD/YY)

Enter the date, month, day, *and year*, the transportation service is to begin. Enter the month, day, *and year* the transportation service is to end. **The dates of purchase/service must be within the same calendar month**. ***Payment cannot be made if the invoice indicates dates of purchase/service in different months***. Indicate the type of transportation service to be purchased for the dates indicated, either multi-ride transportation service, monthly transportation service, or other service.

RESOURCE #

Enter the provider's Resource # supplied by DHHS at the time of provider enrollment. ***Note*: Enter only the digits assigned, beginning with the first box at the left. Leave any remaining boxes blank.**

TOTAL COST OF TRANSPORTATION SERVICE FOR THIS RECIPIENT

Enter the total cost of the type of transportation service authorized by the NHEP Representative and purchased by the recipient for the dates indicated. **Only transportation service for one recipient for one month may be billed on this invoice.**

TRANSPORTATION PROVIDER'S SIGNATURE

The transportation provider must sign and date the invoice.

DISTRIBUTION

The **White** copy is sent by the transportation provider to the following address:

Department of Health & Human Services
Data Management Unit
P.O. Box 2000
Concord, NH 03302-2000

The **Canary** copy is retained by the transportation provider.