NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES

CTS

New Hampshire Medicaid's Fee-For-Service Program

(Not To Be Used by Managed Care Members)

Request for Reimbursement of Medical Transportation by Private Car, Bus, or Train

Reimbursement for transportation by car, bus, or train to Medicaid covered services will only be allowed if you call CTS in advance of going to the Medicaid covered service so that CTS can verify that the transportation will be covered.

Call: 1-844-259-4780

If more than one passenger is transported, only one claim may be submitted, regardless of the number of passengers. (He-W 574.06 (e))

_____ _____ _____

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

_____ _____

Mailing Address Physical Address (If different than mailing address)

_____ _____ _____

City State Zip Code

For travel by car: Transporter's driver's license #:_____ Driver's license expiration date: _____

Member Traveled by: Car [ ] Bus [ ] Train [ ] **(For travel by bus or train, attach receipt showing amount paid)**

Tolls: Amount Paid:_____ Parking: Amount Paid:_____(**Original receipts must be attached**)

*****This is to 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 the concealment of material fact may be prosecuted under applicable Federal and State Laws. I agree to accept CTS' transportation payment as payment in full. *****

Member's Signature: _____

Payment will be made to you once CTS verifies that the appointment was kept. Payment, if approved, will be issued within 30 days of receipt of claim by CTS. Trips by car are reimbursed at $.31 per mile.

TO BE COMPLETED BY YOUR MEDICAID PROVIDER ONLY--PLEASE PRINT

_____

Physician/Medicaid Provider/Clinic Name/Pharmacy Name

_____

Street Address City State Zip Code

Dates of Medicaid Covered Services

_____

_____

_____

_____

_____

_____

_____

I attest that the patient named above visited my office/clinic/pharmacy for non-emergency medical appointment(s) or Medicaid covered pharmaceuticals on the date(s) as noted.

By:__/_____

Physician/Medicaid Provider Signature / D a t e Signed

_____

National Provider Identifier (N.P.I.)

Forms must be submitted within 90 calendar days from the last date of service on the form to: **Coordinated Transportation Solutions, Inc., 35 Nutmeg Drive Suite 120, Trumbull, CT 06611, or scanned and e-mailed to CTS at provider@ctstransit.com, or Faxed to (203) 375-0516. Questions regarding payment may be directed to the Finance Department at 1-844-259-4780; select option #5**

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NOTE: This document expires **90 calendar days** after the last date of service on the form.