Medicaid Fee For Service
(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; selection option # 4

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 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 [ ] **(Original receipts showing amount paid must be attached for travel by bus or train)**
Tolls: Amount Paid: _______ Parking: Amount Paid: ________ (**Original receipts for tolls and parking 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 $0.41 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 / Date Signed
______________________	
______________________	______________________________
______________________	National Provider Identifier (N.P.I.)
______________________	
______________________	

Forms must be submitted within 60 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 FF@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 **60 calendar days** after the last date of service on the form.