AmeriHealth Caritas New Hampshire

CTS CONNECTING PEOPLE WITH CARE

Request for Reimbursement of Medical Transportation by Private Car

Reimbursement for transportation by car to Medicaid covered services will only be allowed if you call Coordinated Transportation Solutions (CTS) in going to the Medicaid covered service so that CTS can verify that the transportation will be covered.

Call: 833-301-2264, select option #6 / Email: FF@ctstransit.com **/ Fax: (203) 375-0516**

In order to receive reimbursement this form must be completed in its entirety. If any portion of this form does not apply to you write "N/A."

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 Full Name: First Name, Middle Name, Last Name (printed)

Mailing Address

Physical Address this must be your starting location as registered with NH Medicaid. **If starting address is not the same as your physical address on file the claim will be denied in accordance with He-W 574.**

City _____ State _____ Zip Code _____ Member's Medicaid ID Number _____

For travel by car:

Driver's Name: First, Middle, Last (printed): _____ Driver's license state & number: _____

Driver's license expiration date: _____ Driver's signature: _____

Drivers DOB: _____ Vehicle license plate number / State _____

Driver's relationship to member (if you drive yourself write "self"): _____

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 or altered 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 but understand that I have the right appeal the reimbursement amount.*****

Payment will be made to you once CTS verifies that the appointment was kept and meets the requirements of He-W 574. Payment, if approved, will be issued within **30** days of receipt of claim by CTS. Trips by car are reimbursed at $0.72 per mile.

Member's signature and date signed: _____

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	Provider Initials

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 days from date of service to: **Coordinated Transportation Solutions, Inc, 35 Nutmeg Drive, Suite 120, Trumbull, CT 06611, or scanned, or legible photograph from smartphone should be emailed to** FF@ctstransit.com **or Faxed to (203) 375-0516. Questions regarding payment may be directed to the finance department of CTS at 833-301-2264**

; select option #6

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Note: This document expires 90 days from the date of service

1/13/2026