AmeriHealth Caritas New Hampshire

CTS CONNECTING PEOPLE WITH CARE

Request for Reimbursement of Medical Transportation by Private Car or Rail

You must call CTS 48 hours in advance of any non-urgent medical appointment to get pre-approved to participate in the Medical Transportation Reimbursement Program. Reimbursements will not be issued for transportation to medical appointments that were not approved in advance of the appointment. Reimbursement of medical transportation expenses will be considered without 48 business hours' notice for urgent appointments if approved by CTS prior to the medical appointment.

Please be careful not to submit duplicate claims. If more than one passenger is transported in the same trip, only ONE passenger can submit for reimbursement.

Submit completed reimbursement forms to: Coordinated Transportation Solutions, Inc., 35 Nutmeg Drive, Suite 120, Trumbull, CT 06611; Phone: **(833)301-2264**; Fax: **(203)375-0516**

Member's Name _____ Member's AmeriHealth Caritas Member ID# _____ Date _____

Mailing Address _____ Physical Address (if different from mailing address) _____

City _____ State _____ Zip Code _____

*** 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.

Member Signature: _____

Coordinated Transportation Solutions, Inc. (CTS) will review and approve the members request for medical transportation. Payment will be made to the member once CTS has verified that the appointment was kept. The member must submit completed forms no later than 60 calendar days after the month that the appointment took place. The member must only be entering one calendar month per form per treating physician.

Total reimbursement for the month is calculated in the following way: In-town trips will be reimbursed at $0.65 per mile and Out-of-Town trips will be reimbursed at $0.65 per mile.

TO BE COMPLETED BY YOUR MEDICAL PROVIDER ONLY – PLEASE PRINT

Physician/ Medical Provider/Clinic Name _____

Street Address _____ City _____ State _____ Zip code _____

Patient Traveled by: Car ☐ Bus ☐

Dates of Medical Service	**I attest that the patient named above visited my office/clinic for non-emergency medical appointment(s) on the date(s) as noted:**
	Physician Name/Medical Provider Signature:
	National Provider Identifier (NPI):
	Date:

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