First Transit
Colorado NEMT

MILEAGE REIMBURSEMENT VERIFICATION FORM - SUBSCRIPTION

Please complete this form and return it to First Transit – Colorado NEMT within fourteen (14) days of the last medical appointment for reimbursement. For questions, please call First Transit – Colorado NEMT at 855.OPS.NEMT (855.677.6368) or check out our web page at www.medicaidco.com .

Medicaid Client Name: _____ Medicaid ID #:_____

Name of Medical Provider: _____

Medical Facility Address: _____ City: _____

Name of Authorized Signer: _____

Title: _____ Contact Phone #:_____

Dates Seen – Do not Enter more than 14 Appointment Dates

_____ _____

Signature Date

TRANSPORTATION PROVIDER INFORMATION

PLEASE COMPLETE FOR REIMBURSEMENT

Provider Name: _____ Currently Registered? ❑ Yes ❑ No

(Name to Appear on Reimbursement Checks)

If you are not yet registered, please enter the following information:

Mailing Address: _____

City: _____ State: _____ Zip: _____

First Transit – Colorado NEMT generates reimbursement checks every two (2) weeks. Please see our webpage for a schedule. All reimbursement requests MUST be submitted within fourteen (14) days of the client's last trip.

Return via USPS mail to: First Transit, 13111 East Briarwood Avenue, Suite 260, Centennial, CO 80112 or email to mileageco@firstgroup.com or fax to: 303.790.4386

With my signature, I hereby acknowledge that the above named Medicaid client was seen by our office on the dates identified above.

FOR FIRST TRANSIT – COLORADO NEMT ONLY

DO NOT WRITE IN THIS BOX

RM Confirm: _____ Distance: _____ Value: _____