First Transit
Colorado NEMT

MILEAGE REIMBURSEMENT VERIFICATION FORM

Please complete this form and return it to First Transit – Colorado NEMT within fourteen (14) days of the 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/mileage.

Medicaid Client Name: _____ Medicaid ID #:_____

Date of Trip: _____ Appointment Time: _____ AM PM

Please circle as appropriate .

Name of Medical Provider: _____

Medical Facility Address: _____ City: _____

Name of Authorized Signer: _____

Title: _____ Contact Phone #:_____

_____ _____

Signature Date

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

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 (Cannot be a PO Box): _____

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 trip.

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

FOR FIRST TRANSIT – COLORADO NEMT ONLY

DO NOT WRITE IN THIS BOX

RM Confirm: _____ Distance: _____ Value: _____