WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

SUPPLEMENT TO APPLICATION FOR NEMT REIMBURSEMENT PROGRAM

This supplemental sheet is used with the DFA-NEMT-1 and contains space for 3 additional trips for a total of 4 per application. Application must be received by DHHR **within 60 days of the date of the first trip**.

IMPORTANT: Payment will be made to the person or company named on each verification form. If you provide your own transportation, you must enter your own name and address in this section as the Driver. If the wrong name and/or address is entered, duplicate payment will not be made. Payment cannot be processed unless the Driver's SSN or tax ID number is entered.

Mileage is reimbursed at the current state mileage reimbursement rate for the shortest round-trip route from the patient's home to the medical facility or physician's office. Lodging must be pre-approved for the most economical rate and must be verified as necessary due to the length of travel, time of appointment, and/or length of treatment. Meals are reimbursed only when lodging has been approved. Additional reimbursement may be made for tolls and parking, as appropriate.

VERIFICATION OF TRAVEL AND ATTENDANCE FOR NEMT

Medical Provider: Do not sign if the medical service/treatment is not billable or billed to the Medicaid Program.

For DHHR Use Only:
MA ID _____
Driver's VN _____

Patient's Name _____ SSN _____

Purpose of Visit: Routine ☐ Follow-up ☐ Walk-in ☐ Initial ☐

Name and Address of Medical Provider _____

Date of Appointment _____ Time of Appointment _____

_____ _____
Signature of Medical Provider or Authorized Representative Date

Transportation Provider: Private Vehicle ☐ Taxi ☐ Bus ☐ Plane ☐ Community Van ☐ Other ☐

_____ _____
Driver's/Carrier's Name (Please print) SSN or Tax ID

Driver's Signature _____ Date _____

Mailing address _____ Phone _____

Private Vehicle Cost: Mileage_____ Parking _____Tolls _____
Common/contract Carrier: Round-trip fare _____
Lodging: Cost per night _____ Number of nights_____
Meals: Number of persons_____ Number of meals per person_____

(Receipts must be attached for lodging, parking and common carrier fare.)

For DHHR Use Only:
Miles _____X_____=_____
Total lodging _____
Other costs _____
Total for this trip _____

The back of this sheet provides space for 2 additional trips. This form must be attached to the DFA-NEMT-1 (NEMT application form) if you are requesting reimbursement for more than one trip.

VERIFICATION OF TRAVEL AND ATTENDANCE FOR NEMT

Medical Provider: Do not sign if the medical service/treatment is not billable or billed to the Medicaid Program.

For DHHR Use Only:
MA ID _____
Driver's VN _____

Patient's Name _____ SSN _____

Purpose of Visit: Routine ☐ Follow-up ☐ Walk-in ☐ Initial ☐

Name and Address of Medical Provider _____

Date of Appointment _____ Time of Appointment _____

_____ _____
Signature of Medical Provider or Authorized Representative Date

Transportation Provider: Private Vehicle ☐ Taxi ☐ Bus ☐ Plane ☐ Community Van ☐ Other ☐

_____ _____
Driver's/Carrier's Name (Please print) SSN or Tax ID

Driver's Signature _____ Date _____

Mailing address _____ Phone _____

Private Vehicle Cost: Mileage_____ Parking _____Tolls _____
Common/contract Carrier: Round-trip fare _____
Lodging: Cost per night _____ Number of nights_____
Meals: Number of persons_____ Number of meals per person_____

(Receipts must be attached for lodging, parking and common carrier fare.)

For DHHR Use Only:
Miles _____X_____=_____
Total lodging _____
Other costs _____
Total for this trip _____

VERIFICATION OF TRAVEL AND ATTENDANCE FOR NEMT

Medical Provider: Do not sign if the medical service/treatment is not billable or billed to the Medicaid Program.

For DHHR Use Only:
MA ID _____
Driver's VN _____

Patient's Name _____ SSN _____

Purpose of Visit: Routine ☐ Follow-up ☐ Walk-in ☐ Initial ☐

Name and Address of Medical Provider _____

Date of Appointment _____ Time of Appointment _____

_____ _____
Signature of Medical Provider or Authorized Representative Date

Transportation Provider: Private Vehicle ☐ Taxi ☐ Bus ☐ Plane ☐ Community Van ☐ Other ☐

_____ _____
Driver's/Carrier's Name (Please print) SSN or Tax ID

Driver's Signature _____ Date _____

Mailing address _____ Phone _____

Private Vehicle Cost: Mileage_____ Parking _____Tolls _____
Common/contract Carrier: Round-trip fare _____
Lodging: Cost per night _____ Number of nights_____
Meals: Number of persons_____ Number of meals per person_____

(Receipts must be attached for lodging, parking and common carrier fare.)

For DHHR Use Only:
Miles _____X_____=_____
Total lodging _____
Other costs _____
Total for this trip _____