INSTRUCTIONS FOR COMPLETING FORM 13A:
MEDICAID TRANSPORTATION REIMBURSEMENT FORM

PAYEE INFORMATION:

Key Name: Print the Key Name received upon enrollment. If you do not have a key name or have not been enrolled, contact the Medicaid Transportation Coordinator at 1-800-852-3345, ext.3770 (in-state only) or (603) 271-3770.

Resource #: Print the assigned Resource Number received upon enrollment. If you do not have a Resource Number or have not been enrolled, contact the Medicaid Transportation Coordinator at 1-800-852-3345, ext. 3770 (in-state only) or (603) 271-3770.

Payee Name: Print the first and last name, full mailing address, physical address (if different than the mailing)and telephone number of the person who will receive the payment.

Relationship to Recipient: Check the box that applies to your relationship to the recipient.

RECIPIENT INFORMATION:

First Name: Print up to the first three letters of the first name of the Medicaid recipient.

Last Name: Print up to the first three letters of the last name of the Medicaid recipient.

Medicaid ID #: Print the Medicaid recipient's individual number from his/her Medicaid card.

TRIP INFORMATION: PLEASE COMPLETE ONE SIDE OR THE OTHER, **NOT BOTH**

If payee is **Self or Parent/Household Member (Recipient Transporter)**	**OR:**	If payee is **Volunteer**
From: Print up to the first 8 letters of the Recipient's home town or city, and the zip code.		From: Print up to the first 8 letters of the Volunteer's hometown or city, and the zip code.
To: Print up to the first 8 letters of the Medical Provider's town or city and state.		To: Print up to the first 8 letters of the Recipient's home town or city.
		To: Print up to the first 8 letters of the Medical Provider's town or city and state.

One Way/Round Trip: Check if the trip was made only one way, or if it was round trip (round trip means to the medical provider and return to the recipient's home).

Total Miles per Trip: Enter the number of miles traveled on the trip date. For volunteers, total miles should be from your residence and return if it was round trip. (Leave blank if provider type code is B). This needs to be **whole** miles only. (For example: If you travel 25.2 miles, enter 25. If you travel 25.7 miles, enter 26.)

Tolls/Parking/Bus: If tolls and parking for this trip total $3.00 or more, enter the total amount. Enter full bus fare, if applicable. Receipts containing the trip date must be attached and must show the same trip date as stated on the claim form.

Medicaid Provider Name & Facility/Group they work for: Print the name of the medical service provider, in last name, first name order. Example: *SMITH, JOHN; ABC PEDIATRICS*

Address of Medicaid provider where services were rendered: Enter the street address including the city and state where services were rendered.

Medical Provider Type Code: Enter the provider type code from the list in the shaded area below the code (1, 2, 3, etc.) Be very careful when selecting the code, as there are limits on each. **Please note: specialists, regardless of where they are seen, need to be coded w/a "6". Please call if you have questions.**

Trip Date: Enter the month, day and year the medical service was provided. This should be the date the transportation was provided.

CPT/CDT: You may be asked by the Transportation Coordinator to have the medical provider's office enter the code corresponding to the services rendered to ensure validation of coverage.

Medical Provider/Pharmacy Signature: The Medicaid recipient (patient), or their authorized representative, is responsible for obtaining the medical provider's signature on this claim form at the time of service. **The medical provider or a member of his/her staff must sign and date this form on the same day of the trip. If the provider is using a signature stamp, both the yellow and white copies must be stamped.**

Recipient Signature and Date: The Medicaid recipient must sign and date the form. If the recipient is a minor, the parent or legal guardian must sign on his/her behalf.

Payee Signature and Date: The payee signs and dates the form after s/he has made sure the form is complete.

PROCESSING INFORMATION: Claims must be received by the Medicaid Transportation **within 90 days of the date of service** on the claim. No reimbursement will be made for claims received after 90 days from the trip date.

For payment, send the white copy of this claim to: Medicaid Transportation, 129 Pleasant St, Thayer Bldg; Concord, NH 03301

Keep the yellow copy for your record so that you may compare the claim for services provided with the payments received. Please allow 6 to 8 weeks for payment of a claim. Claims that contain errors may need to be returned to you for correction.

State of New Hampshire
Department of Health and Human Services

13A Web
07/12

OMBP Use Only
F-__________ Auth:_____________
F-__________ Auth:_____________
F-__________ Auth:_____________

MEDICAID TRANSPORTATION REIMBURSEMENT FORM

****INSTRUCTIONS ON BACK OF FORM****

PAYEE /RESOURCE INFORMATION

Key Name: ___ ___ ___ ___ ___ **Resource #:** ___ ___ ___ ___ ___ ___ ___ ___

Payee Name (Enrolled Driver) and Address:

____
First Last

__________________ ________________________
Mailing Address Physical Address (If different than mailing)

________________ _____ ________
City/Town State Zip Code

Telephone # (   ) ____________________

Relationship to Recipient: (Check one)

☐ 1. Self
☐ 2. Parent or Household Member
☐ 3. Volunteer

Service Code: (Check One)

☐ (RT) Recipient Transporter
☐ (VT) Volunteer Transporter

RECIPIENT INFORMATION (person receiving Medicaid services)

___ ___ ___ Recipient First Name (1st 3 only)
___ ___ ___ Recipient Last Name (1st 3 only)
___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Recipient Medicaid ID Number

TRIP INFORMATION

***Recipient Transporter* Trip Information**

From:
___ ___ ___ ___ ___ ___ ___ ___ (Recipient's Home Town/City) ___ ___ ___ ___ ___ (Zip Code)

To:
___ ___ ___ ___ ___ ___ ___ ___ (Medical Provider's Town/City) ___ ___ (State)

OR

***Volunteer Transporter* Trip Information**

From:
___ ___ ___ ___ ___ ___ ___ ___ (Volunteer's Home Town/City) ___ ___ ___ ___ ___ (Zip Code)

To:
___ ___ ___ ___ ___ ___ ___ ___ (Recipient's Home Town/City)

To:
___ ___ ___ ___ ___ ___ ___ ___ (Medical Provider's Town/City) ___ ___ (State)

☐ 1. One Way Trip
☐ 2. Round Trip

___ ___ ___ Total **Whole** Miles Per Trip (**NO Decimals**)

$___ ___.___ ___ **Tolls/Parking/Bus** (Minimum $3.00, Receipts Required) (***Bus** has no minimum*)

☐ Receipts Verified **OMBP Use Only**

$___ ___ ___.___ ___ **OMBP Use Only**

Name of Enrolled NH Medicaid Provider & Facility/Group they work for:

____

____

Medical Provider Type Code: ☐
(See list below in shaded area)

Address of Medicaid provider where services were rendered

____

Medical Provider Type Codes: ***(Select Carefully, see instructions)***

[1] Hospital	[4] Therapies (Physical/Speech/Occupational)	[7] Pharmacy
[2] Physician/Mental Health Provider	[5] Dialysis	[A] Medicaid Use Only
[3] Dentist	[6] Referral/**Specialist** *** (See back of form)	[B] Bus Transportation with receipts

*****Medical Provider/Pharmacy Signature & Date** (***must be signed on date of service***)

Trip Date (MM/DD/YY)

I certify that NH Medicaid covered services were rendered for this recipient on the trip date indicated.

___ ___ /___ ___ /___ ___ ________ *** CPT/CDT Code** ____________________ **Signature** ____ __ ____ **Today's Date**

***__If Pharmacy__, do you provide free delivery to recipient's residence? ☐Yes ☐No ***__Is the RX covered by Medicare Part D?__ ☐Yes ☐No

*****This is to certify that the information above 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.**

Recipient Signature:__________________________ Date:__________________

Payee Signature:__________________________ Date:__________________