

# Customer Reimbursement Form



## Medical Provider Only:

The person named below was seen by the MaineCare covered service provider named below on:

\_\_\_\_\_

Please have your MaineCare provider complete and **sign** this Form. Return Form to:

200 Main Street  
Ansonia, CT 06401  
Phone: (855) 262-0568  
Fax: (203) 732-3370; (203)736-8816  
E-mail: provider@ctstransit.com

**I attest that the patient named below visited my office/clinic for non-emergency MaineCare service(s) on the date(s) indicated:**

\_\_\_\_\_  
**Physician/Medical Provider Signature**

**MaineCare  
NPI#** \_\_\_\_\_

A. Name of the Member with Appointment: \_\_\_\_\_

B. Physical Address of the Member: \_\_\_\_\_

C. Telephone # of the Member: \_\_\_\_\_

D. Name of the MaineCare Provider or Facility: \_\_\_\_\_

E. Complete Address of the Facility:

TripDate(s): \_\_\_\_\_

Miscellaneous (parking, tolls- original receipts are required, specify exact amount)

Tolls: \_\_\_\_\_ Meals \_\_\_\_\_

Parking: \_\_\_\_\_ Other \_\_\_\_\_

**You must call CTS 48 business 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 trips to medical appointments that were not approved by Coordinated Transportation Solutions (CTS) in advance of the appointment. Approvals for reimbursement of Medical Transportation expenses will be considered without advance notice of 48 business hours for urgent appointments, if approved by CTS before the medical appointment.**

## Driver's Name, Address, and License Information:

F. \_\_\_\_\_  
Name, Middle Initial, and Last Name

J. \_\_\_\_\_  
Driver's License Number/ State

G. \_\_\_\_\_  
Street or PO Box

K. \_\_\_\_\_  
Driver's License Expiration Date

H. \_\_\_\_\_  
City, State and Zip

I. \_\_\_\_\_  
Telephone Number

Signature of Member: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Driver: \_\_\_\_\_ Date: \_\_\_\_\_