Goodhue County Health & Human Services Non-Emergency Medical Transportation (NEMT) Expense Reimbursement Form

Completed/signed form is due within 60 days of date of service. Please complete a separate form for each person.

Return completed form, proofs & receipts to: Goodhue County Health & Human Services, 426 West Avenue, Red Wing MN 55066 (FAX 651-267-4879)

Name of person who had the medical appointment or went to appeal hearing: _____

(Printed – Last, First, MI)

PMI/ID#: _____ **Case #:**_____ **Date of birth:** _____ **Own car used** ☐ **Driver's Car used** ☐

Transportation provider/driver's name: _____ **Driver License #**_____

(Printed – Last, First, MI)

Transportation provider/driver's address: _____ **Vehicle License #:** _____

Payment to be made to: _____ **Address** _____

Date of service (mm/dd/yy)	Pick-up address	Pickup Time incl AM/PM	Destination Address (Medical Provider or Facility Name and address/city)	Drop-off time incl AM/PM	Round trip: Y/N	Total Miles (Most Direct Route)	Parking/ Meals (Attach receipts)	Appointment MUST be verified (destination provider signature/name/location, discharge papers, EOB, etc)
								Provider signature Date
								Provider signature Date
								Provider signature Date
								Provider signature Date
								Provider signature Date
								Provider signature Date

Driver statement/signature: I certify that I have accurately reported in this record the trip miles I actually drove and the dates and times I actually drove them. I understand that misreporting the miles driven and hours worked is fraud for which I could face criminal prosecution or civil proceedings.

_____ _____

(Signature of driver) (Date)

Claimant statement/signature: I declare under penalties of perjury that I am making this claim; that I have examined the claim and that it is just and true; that the services charged were actually delivered or used for the purpose stated; that the services were of the value charged, and that no part of this claim has been paid**.**

_____ _____ _____

(Signature of claimant) (Date) (Telephone Number)

* RTS-Refused to Sign; * UTS –Unable to Sign

Equal Opportunity Employer

TO: Minnesota Health Care Program enrollees FROM: Goodhue County Health & Human Services

Below is information on completing the Non-Emergency Medical Transportation (NEMT) Expense Reimbursement Form:

- Fill out one line on the Expense Reimbursement Form for each separate medical or dental appointment. You can have more than one appointment on the same form.
- Complete a separate form for each person.
- Only report miles traveled with recipient in the car. This is referred to as "loaded miles".
- Have the health care provider sign the designated line verifying appointment [or you can provide other proof that the appointment took place such as a copy of the Explanation of Benefits (EOB), discharge papers]. All proofs must be included with the Expense Reimbursement Form when submitted for payment.
- Complete all fields and include all required signatures. If all information is not entered on the Expense Reimbursement Form, the form will be returned and reimbursement will not be made.
- Mail or fax completed Expense Reimbursement Form to the address/fax number included on the form within 60 days of the appointment.
- You can make extra copies of the Expense Reimbursement Form, as needed. You can also request from an Eligibility Worker or download a copy from the Goodhue County website: http://www.co.goodhue.mn.us.

You do not have to add up the number of miles for each appointment. We will figure that out.

If you do not drive but have a friend or family member who can drive you, you still use the same form to submit the information for payment.

If you want to get paid for parking for your medical appointment, send the original or copy of the receipt with the Expense Reimbursement Form. A receipt must include a date printed on it. Indicate if the parking expense is at a meter that does not provide a receipt.

Note: Our agency may call the health provider to confirm that enrollee showed for the appointment.

IMPORTANT: Prior approval is needed for the following transportation/related services:

- All trips over 30 miles from your home to your primary care provider (or 60 miles for a specialty care provider). A statement of medical necessity from the referring or treating physician is required. The statement must show that the provider is the closest provider capable of providing the level of care needed.
- Out of state travel
- All Lodging and Meals. Travel required must be further than 60 miles (most direct route) from home to medical appointment/provider.
- Common carrier transportation such as bus, taxi, and other commercial vehicles (this does not include travel by your own car or that of a friend, family member, neighbor - someone with vested interest).

Please contact an Eligibility Worker in writing, by phone or by email (hhs.imu@co.goodhue.mn.us) at least five (5) days prior to appointment in order to obtain needed prior authorization.

If you have any questions about this letter or the attached Expense Reimbursement Form, please contact an Eligibility Worker at (651)385-3200 or toll free at (800) 950-2142.

Attach ADA/LB2 11-30-2021

1-800-950-2142

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ: ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណាត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ် တီလံာ်မီတခါအံၤနူဉ်,ကိးဘဉ်လီတဲစီနီါဂ်ါလၢထးအံၤနူဉ်တက့်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (8-16)

ADA Advisory

For accessible formats of this information, ask your county worker. For assistance with additional equal access to human services, contact your county's ADA coordinator. ADA4 (1-18)