Non-Emergency MEDICAL Transportation Reimbursement Form

****SENSITIVE BUT UNCLASSIFIED****

Submission Instructions: Attach copies of ALL receipts to support payment of payment amounts ($) requested below. Attach this form to the pre-approved PA3 Non-Emergency Medical Transportation Request form, which should include NIOSH Decision and Comments fields completed. Submit all documents to the HPS contractor via the SFTP server for reimbursement processing.

Medical Transport Code(s):

Member Information / CCE/NPN Provider/Requester Information

Request Date:	Member Category:	CCE/NPN Requester Name:	CCE/NPN Requester Credentials:
Member Name:	**Date of Birth:**	**CCE/NPN Requester Fax:**	**CCE/NPN Requester Phone:**
Member 911#:	**CCE/NPN:**	**CCE/NPN Requester Email:**	
Member Home Address:		**CCE/NPN Requester Office Address:**	

Payee Information

Payee Name:	Payee Address:
Additional Payee Name: (if applicable)	**Additional Payee Address:** (if applicable)

Trip Information

Date/Time(s) of Travel:	Origin:	Destination 1:	Destination 2: (optional)	Destination 3: (optional)
Start Date:	**Name:**	**Name:**	**Name:**	**Name:**
Start Time:	**Type:**	**Type:**	**Type:**	**Type:**
	Address:	**Address:**	**Address:**	**Address:**
End Date:				
End Time:				
	☐ **Same as member's home address**	**Total # of Trips:**	**Total # of Trips:**	**Total # of Trips:**
		Trip Mileage:	**Trip Mileage:**	**Trip Mileage:**

****Please attach all bills and receipts along with the NIOSH approved PA3 Request form****

Total Amount Requested for Reimbursement:

CCE/NPN Medical Director Signature: **Date:**

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Total Amount Approved for Reimbursement: