WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

APPLICATION FOR NON-EMERGENCY MEDICAL TRANSPORTATION PROGRAM (NEMT)

Section I: TO BE COMPLETED BY APPLICANT.
Note: This must be completed **in ink** and turned in to the local DHHR office **within 60 days of the earliest trip**.

Name _____ Date(s) of Travel _____

Street, Route or PO Box Number_____

City _____ County _____ Zip Code_____

Telephone Number _____ SSN _____

MA ID number from each patient's Medicaid card (this is the 11-digit number to the left of the person's name on the card):

_____

_____

Section II: APPLICANT RESPONSIBILITIES AND SIGNATURE

Please read each statement carefully and check either Yes or No.

1. ( ) Yes ( ) No — I **understand** that I may request a Fair Hearing if I am not satisfied with the decision regarding my application for non-emergency medical transportation payments (NEMT). I may also request a Fair Hearing if I feel that I have been discriminated against because of race, color, national origin, sex, age, religion, or political belief, or because I am disabled. I **further understand** that I may be represented by an attorney at a Fair Hearing, but that neither DHHR nor any of its authorized representatives will pay for the legal services.

2. ( ) Yes ( ) No — I **understand** that I may be asked to verify any or all information on this application form or to provide additional information and that failure to provide this verification or information will result in denial. I **also understand** that alterations on this form must be initialed by me or the application may be denied.

3. ( ) Yes ( ) No — I **understand** that this completed application, including all required verification, must be received by the local DHHR office no later than 60 days from the date of the trip for which I am requesting payment. I **further understand** that if the application or verification is received 61 or more days after the trip, that my application will be denied.

4. ( ) Yes ( ) No — I **understand** that I am to use the least expensive transportation available, taking into consideration my physical condition and the travel locations.

5. ( ) Yes ( ) No — I **understand** that the following expenses must be approved before the trip is taken: lodging, out-of-state transportation, double round trips on the same day and requests for an immediate family member to stay with a patient at a medical facility. Receipts for lodging must be provided with the application.

6. ( ) Yes ( ) No — I **understand** that meals are permitted for the patient and the driver of a private vehicle when overnight lodging is approved. All meals are the responsibility of the patient and driver when an overnight stay has not been approved.

7. ( ) Yes ( ) No — I **understand** that waiting time charges for a taxi may be included for travel from city to city, but not within the city of taxi operation.

8. ( ) Yes ( ) No I **understand** that neither DHHR nor any of its employees is responsible for any damages from an accident which may occur during the trip for which I am requesting payment.

9. ( ) Yes ( ) No I **understand** that the Criminal Investigations Unit investigates all allegations of NEMT program abuse and, when warranted, refers such cases for prosecution under WV Code 61-3-24. I **further understand** that criminal penalties may include jail/prison sentences and/or fines. In addition, I **understand** that I may also be required to repay any benefits to which I was not entitled.

10. ( ) Yes ( ) No I **understand** that my signature means that I have read, or had someone read to me, all statements on this form and that I understand all questions. My signature also **indicates** that these expenses are not reimbursable by anyone else and that all information given is true and correct to the best of my knowledge.

Applicant's Signature _____ Date_____

Section III: VERIFICATION OF TRAVEL AND ATTENDANCE

NOTE: The following section requires signatures from the medical provider or representative and from the Driver or other transportation provider. Please fill out in ink and initial any changes or corrections after striking out the information in error. Do not use correction fluid or tape. Additional trips (up to a maximum of 4) may be listed using the OFS-NEMT-1a supplemental form which must be attached to this application.

VERIFICATION OF TRAVEL AND ATTENDANCE FOR NEMT

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

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

Patient's
Name_____ SSN_____

Purpose of Visit: Routine_____ Follow-up _____ Walk-in _____

Name and Address of Medical Provider_____

Date of Appointment _____

_____
Signature of Medical Provider or Authorized Representative Date

Transportation (circle one): 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 fares.)

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