LAND OF SKY TRANSPORTATION RESOURCE CENTER
A PROGRAM OF LAND OF SKY REGIONAL COUNCIL

Non-Emergency Medicaid Transportation
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BENEFICIARY REIMBURSEMENT
NON-EMERGENCY MEDICAID TRANSPORTATION (NEMT)

To be filled in by the NEMT Transportation Resource Center

Recipient Name: _____

Recipient ID #: _____ Eligibility Category Code: 250

REIMBURSEMENT AUTHORIZATION

Period of Authorization From: _____ To: _____

Reimbursement for travel expenses **Total Travel:** _____

Reimbursement for mileage at a cost of **$0.29** per mile **Other Expenses:** _____

Date: _____

Worker Initials: _____ **Payment:** $ _____

To be filled in by RECIPIENT

RECIPIENT
I CERTIFY THAT THIS REIMBURSEMENT REQUEST IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

(PRINT) Name: _____

Signature: _____ Date: _____

Address: _____

_____

FY 2016