



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 \$0.2725 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: \_\_\_\_\_

\_\_\_\_\_