CONNECTING PEOPLE WITH CARE

Medicaid Fee for Service

AmeriHealth Caritas New Hampshire

Family and Friends Mileage Reimbursement Program

New Driver Enrollment Sheet

Full Name of Member: _____ **Date:** _____

Medicaid ID Number :_____

Home Address: _____ **Date of Birth:** _____

Vehicle and Driver Information being used for Mileage Reimbursement Program:

Driver License Number and State: _____

Expiration Date:_____

License Plate Number / State of Primary Vehicle: _____

Please list the Driver Name (First, Middle, Last)(Printed): _____

Date of Birth: _____

Additional / Alternative Vehicle and Driver Information being used for Mileage Reimbursement Program:

License Plate Number / State of Primary Vehicle: _____

Please list the Driver Name (First, Middle, Last): _____

Date of Birth: _____

I, the member, hereby understand and agree that: (initial next to each)

___ participation in the Family and Friends Program is both voluntary and a privilege and that failure to comply with any of the rules of the program may result in my immediate termination from this mileage reimbursement program

___ Medicaid fraud is a serious crime and fraudulent submissions for reimbursement under this program can result in criminal penalties up to 7 years in State prison

___if I move I must update and provide proof of my new address to [Medicaid] before I submit my next reimbursement form

___driver must have a valid driver's license in order to receive reimbursement under this program

___ driving without a license, driving with a suspended license, or driving while designated as a habitual offender are all crimes in New Hampshire and submissions made under this program can and will be used against me in criminal proceedings

___ if the New Hampshire Department of Health and Human Service or its partners has reason to suspect any potential violations of the Family and Friends Program I understand that my driver's history, motor vehicle records, and/or my criminal background may be checked

___ having a criminal history or driving record does not necessarily prevent me from participating in this program

___ my participation in this program will be governed in accordance with the Department of Health and Human Services Administrative Rule He-W 574

Documentation Required to be Included in this Application

Please send the completed form, along with a copy of the license for each driver listed in the form, by text photo, fax, or email to CTS:

Coordinated Transportation Solutions, Inc,
35 Nutmeg Drive, Suite 120,
Trumbull, CT 06611,

Or a scanned or legible photograph from smartphone should be emailed to FF@ctstransit.com or Faxed to (203) 375-0516.

Please complete additional forms if you need to register more drivers.

Applicant Signature and date: _____

The above signed hereby agrees to all initialed statements above and swears that all information contained in this application and the information in the accompanying documents is true and accurate and that any material falsities contained herein may result in a prosecution for false swearing under RSA 641:3