

INSTRUCTIONS FOR FORM 14

**MEDICAL TRANSPORTATION ENROLLMENT FORM**

Enrollment Instructions for Medical Transportation Payees:

\*\*Please check whether this is a new enrollment or whether you're making a change to your information on file. If you have moved please be sure to list the date of your move.

Do you wish to enroll as: (Place a check mark in the appropriate box on Form 14) See below for appropriate selection.

- Recipient Transporter: Select this option if you transport either yourself (if you are Medicaid eligible) and/or a Medicaid eligible recipient who resides in your household or your child regardless of where they live (minor or adult). Select this option if you take the bus and need reimbursement.
- Volunteer Transporter: Select this option if you are transporting someone outside of your household, who is not your child (minor or adult). If you are a Volunteer Transporter, you must use your own vehicle. You must provide a copy of your current driver's license and proof of automobile liability insurance that states the effective date and expiration date of the insurance. **\*\*\*If you do not provide this information, enrollment cannot be completed and payment cannot be made.**

Payee's Name: Enter your name, or business name as registered with the IRS, in last name, first name order. Leaving a space between your last and first name and between words in your business name.

Payee's Telephone Number: Enter your telephone number including your area code or a telephone number where you can be reached. Entry should include the area code and be in xxx-xxx-xxxx format. This field must be completed in order for payment to be made.

Mailing Address/PO BOX: Enter your street address or PO Box, including the City or Town, State and Zip Code, leaving a blank space between numbers and words.

Physical Address: Enter your physical address, if different than your mailing address, including the City or Town, State and Zip Code, leaving a blank space between numbers and words.

Payee's Social Security Number or Payee's Federal ID Number : Enter either your Social Security Number or your Federal ID. Social Security number should be in xxx-xx-xxxx format, federal identification number should be in xx-xxxxxxx format. One of these fields must be completed in order for payment to be made.

I have read and understand the Summary Form (930) for the program: You must read the form and indicate yes here in order to be enrolled into the program. **\*\*\*If you have questions please call us.\*\*\*\*\***

Payee Signature: Payees must sign and date Form 14.

**\*\*\*SHADED AREAS ON FORM 14 ARE FOR STATE USE ONLY\*\*\***

**\*\*Mail completed Form 14 and copies of any required documentation to: Medicaid Transportation, 129 Pleasant Street, Thayer Building, Concord, NH 03301-8575.**

Keep a copy of the completed Form 14 for your records.

When enrollment is complete, you will receive a computer-generated document, which will provide you with your key name and resource number(s). This information is very important, as it is required on every claim form you submit for payment. **\*\*\*Please allow up to 3 weeks for processing.**

**Medicaid Transportation Office:** (800) 852-3345 extension 3770 or (603) 271- 3770  
(800) 852-3345 extension 4344 (then extension 115) or (603) 271-4344 extension 115

**\*\*\*\*\*Please contact us if you have any questions\*\*\*\*\***

# MEDICAID TRANSPORTATION ENROLLMENT FORM

## \*\*\*\*\*INSTRUCTIONS ON BACK OF FORM\*\*\*\*\*

What do you wish to do? (Please Check One of the below)

Enroll for Mileage/Bus Reimbursement     Change/Update information    \*\*\*\*\*Date you moved \_\_\_\_\_

**DO YOU WISH TO ENROLL AS A:** (Please check **one** box only. A separate Form 14 is required if you wish to enroll as a second type of transporter.)

**Recipient Transporter**     (Transports themselves, household member, their child or is a bus passenger)

**Volunteer Transporter**     (Transports clients not in their household and is not the parent of client.)

**Payee's Name (Last, First, Middle Initial)**

**Payee's Telephone Number**

\_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Mailing address/PO Box:**

**Street/PO Box**

**City or Town**

**State**

**Zip Code**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Physical Address:**

**Street**

**City or Town**

**State**

**Zip Code**

(If different than Mailing)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Payee's Social Security Number    OR    Payee's Federal I. D. Number (All businesses are required to submit a W-9)**

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**I have read and understand the Summary Form (930) for the program:**     Yes     No

**I agree to accept up to the maximum New Hampshire Medicaid mileage allowance per trip as payment in full.**

Payee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**(Shaded boxes are for State use only)**

Payee Number	Code	Local District Office	Resource #
_____	_____	_____	_____
W-9 Attached: <b>Y</b> or <b>N</b> (circle one)		1099 Required: <b>Y</b> or <b>N</b> (circle one)	
<b>CREENTIALS:</b>	<b>Internal Notes:</b>		
RT or VT (circle one)	_____		
Provider Enrollment Date	_____		
____/____/____	_____		
Driver's License Expiration Date	_____		
____/____/____	_____		
Auto Insurance Expiration Date	_____		
____/____/____	_____		
First submission on old form received on _____		Initials _____	

Transportation Coordinator Signature: \_\_\_\_\_

Date: \_\_\_\_\_