

Want your friend or family member to give you a ride?

We'll reimburse them!*

Fallon Health is a company that cares. We want to make getting a ride as easy as possible for our members. We provide mileage reimbursement to your friends and family who give you pre-approved rides. The Friends and Family benefit is for members of NaviCare® SCO and HMO SNP.

Here are some examples of places you can go and be reimbursed:**

- Grocery store
- Doctor visits
- Gym
- Behavioral health appointments
- Pharmacy
- Other health care appointments
- Religious services

What you need to do:

1. Call Coordinated Transportation Solutions (CTS) at 1-833-824-9440 (TRS 711) **when you know you'll need a ride.** They're open Monday–Friday from 8 a.m.–8 p.m. (Oct. 1–March 31, seven days a week). They'll ask you your name and whether your ride is for a medical or non-medical reason.
2. Once you've gotten your ride from a friend or family member, complete the form on the back of this flyer, and submit it to CTS within 60 days of your ride.
 - **If your ride is for a medical/behavioral health appointment, you must have your provider sign the back of this form after you fill it out.**

Important information

- For non-medical trips, you are limited to a 30-mile radius. **There is no radius limit for medical/behavioral health trips.**
- Your reimbursement will be issued by check or direct deposit into your bank account. **You are responsible for reimbursing your friend or family member.**

1-877-700-6996 (TRS 711)

8 a.m.–8 p.m., Monday–Friday (Oct. 1–March 31, seven days a week)

fallonhealth.org/navicare



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**Reimbursement is based upon the CTS mileage calculation and rate of 65.5 cents per mile.*

***Reimbursement to medical/behavioral health appointments is unlimited. Covered rides to other locations are limited to a total of 140 one-way trips per year no matter who provides the transportation service.*



Friends and Family Benefit Reimbursement Form

Three ways to get reimbursed:

1. **Mail** completed form to:
Coordinated Transportation Solutions, Inc.
35 Nutmeg Drive, Suite 120, Trumbull, CT 06611
2. **Email** completed form to: provider@ctstransit.com
3. **Fax** completed form to: 1-203-375-0516

Member information			
Last name		First name	
Street address			
City		State	ZIP
Mailing address (if different from above)			
Member ID number (located on the front of your NaviCare ID card)			
Activity for reimbursement (Please enter a single one-way trip per row, and only list rides from the same calendar month.)			
Travel date	Address (Please check either Non-medical or Medical/Behavioral health.)		
	<input type="checkbox"/> Non-medical <input type="checkbox"/> Medical/Behavioral health	From	To
	<input type="checkbox"/> Non-medical <input type="checkbox"/> Medical/Behavioral health	From	To
	<input type="checkbox"/> Non-medical <input type="checkbox"/> Medical/Behavioral health	From	To
	<input type="checkbox"/> Non-medical <input type="checkbox"/> Medical/Behavioral health	From	To
	<input type="checkbox"/> Non-medical <input type="checkbox"/> Medical/Behavioral health	From	To
Certification and authorization (This form must be signed and dated by the member or authorized representative.)			
Agreement: <i>I certify that the information above is correct to the best of my knowledge. I am claiming reimbursement only for eligible expenses incurred during the applicable benefit year. (A benefit year is January 1 through December 31.) I attest that payments received for Friends and Family transportation will be given to the friend or family member who provided the transportation.</i>			
Member or authorized representative signature: _____ Date: _____			
Please allow 4-6 weeks from receipt of completed form for reimbursement.			
To be completed and signed by your medical/behavioral health provider to verify the appointment(s) listed above. The form must be completed before your provider fills out and signs this section. (One form per provider/clinic.)			
Provider name (PRINT)		Provider signature	
Street address			
City		State	ZIP