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

What you need to do:

1. Call Coordinated Transportation Solutions (CTS) at 1-833-824-9440 (TRS 711) **to pre-schedule your Friends and Family ride.** They're open 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31). 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.**
- **Reimbursements will only be made per ride,** regardless of the number of eligible members in the vehicle traveling to the same or different location.
- **If you didn't pre-schedule your trip,** your reimbursement request may be denied.
- **Need more copies of this form?** Visit fallonhealth.org/navicare and click on "Plan documents and forms" under "Member resources."

1-877-700-6996 (TRS 711)
8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1-March 31)

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**Reimbursement is based upon the CTS mileage calculation and NaviCare allowable rate per mile.*
***Reimbursement to medical/behavioral health appointments is unlimited. Covered rides to non-medical locations are limited to a total of 140 one-way trips per year no matter who provides the transportation service.*

H8928_240613_C Approved 08282024 23-679-108 Rev. 02 8/24

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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.)*		
	❑ Non-medical ❑ Medical/Behavioral health	From	To
	❑ Non-medical ❑ Medical/Behavioral health	From	To
	❑ Non-medical ❑ Medical/Behavioral health	From	To
	❑ Non-medical ❑ Medical/Behavioral health	From	To
	❑ Non-medical ❑ Medical/Behavioral health	From	To

Certification and authorization *(This form must be signed and dated by the member or authorized representative.)*

Agreement:

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.

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