Verification Form for Non-Emergent Medical Transportation (NEMT) Services more than 25 miles

Provider Request

Member Information

First Name: ______________________________ **Last Name:** __________________________________

Date of Birth: __________________ **Health First Colorado ID:** ______________________________

Medical Facility Information

Treatment Location Name: ____

Treatment Location Address: ____

Medical Provider Name and Title: ____

Contact Name and Title: ____

Contact Phone Number: ____

Health First Colorado Provider ID: __________________________________

Reason member cannot be seen by a medical provider less than 25 miles away:

Term of Verification

Date(s) Verification is Valid: _________________________ **Date(s) of Trip:** __________________

Medical Provider Attestation

I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both. I certify under penalty of perjury, that I have obtained the information on the form from the patient or their representative, and the information provided is accurate to the best of my knowledge.

Printed Name of Facility Staff: ____

Faculty Staff Signature: __________________________________**Date**: _____________

This form is valid for 90 days per member for regular trips to treatment locations. This trip must meet the requirements in 10CCR 2505-10 Section 8.014, Non-Emergent Medical Transportation.

Visit the Provider Contact web page if assistance is needed.

Revised 10/2024