COLORADO
Department of Health Care Policy & Financing

Health First COLORADO
Colorado's Medicaid Program

Scheduled Date: ___/___/_____
Scheduled Time: ___: ___ ◯AM ◯ PM

Non-Emergent Medical Transportation Trip Report

Member Information:
Member's Name: Member Medicaid ID #:

Did the Driver verify the member's identity? ◯Yes ◯No
Identity document: ◯Driver's License ◯Health First ID ◯Other

Member's Signature: Date:

Provider/Driver/Vehicle Information:
Provider Name: Medicaid Provider ID#:

Driver's Name: Vehicle Plate #/VIN#:

Type of Vehicle: ◯Ground Ambulance ◯Air/Rotor Ambulance ◯Wheelchair Van ◯Stretcher Van ◯Taxi ◯Mobility/Ambulatory Vehicle ◯Personal Vehicle ◯Public/Mass Transport ◯Commercial Air

Escort Name:

Trip Information: Type of Trip: ◯ ONE WAY ◯ ROUND TRIP

1. Actual Pick-up Time ◯AM ◯PM	Pick-up Street Address	City	State	Zip Code
Actual Drop-off Time ◯AM ◯PM	Drop-off Street Address	City	State	Zip Code

Pick-up Odometer Drop-off Odometer Mileage

2. Actual Pick-up Time ◯AM ◯PM	Pick-up Street Address	City	State	Zip Code
Actual Drop-off Time ◯AM ◯PM	Drop-off Street Address	City	State	Zip Code

Pick-up Odometer Drop-off Odometer Mileage

3. Actual Pick-up Time ◯AM ◯PM	Pick-up Street Address	City	State	Zip Code
Actual Drop-off Time ◯AM ◯PM	Drop-off Street Address	City	State	Zip Code

Pick-up Odometer Drop-off Odometer Mileage

Certification:
Treatment Location/Medical Facility: Representative Name:

Representative Title:

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.

Certifying Signature:

For questions or if you need assistance please visit hcpf.colorado.gov/provider-help