COLORADO
Department of Health Care Policy & Financing

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.

Our mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources. hcpf.colorado.gov