



Non-Emergency Medicaid Transportation
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 Asheville, NC 28806
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BENEFICIARY REIMBURSEMENT
NON-EMERGENCY MEDICAID TRANSPORTATION (NEMT)

To be filled in by the NEMT Transportation Resource Center

Recipient Name: _____
 Recipient ID #: _____ Eligibility Category Code: _____ 250

REIMBURSEMENT AUTHORIZATION

Period of Authorization From: _____ To: _____
 Reimbursement for travel expenses **Total Travel:** _____
 Reimbursement for mileage at a cost of \$0.3125 per mile **Other Expenses:** _____
Date: _____
 Worker Initials: _____ **Payment:** \$ _____

To be filled in by RECIPIENT

RECIPIENT

I CERTIFY THAT THIS REIMBURSEMENT REQUEST IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

(PRINT) Name: _____
 Signature: _____ Date: _____
 Address: _____
