Mass Transit Supervisor
P.O. Box 464 North
Haven, CT 06473 Phone:
866-684-0409 ext 226 Fax:
877-457-3334

REIMBURSEMENT REQUEST FORM
HOSPITAL - FACILITY PROGRAM

INITIAL DISBURSEMENT ☐

PLEASE PRINT CLEARLY

DATE: _____

PAYABLE TO: _____

NAME: _____

ADDRESS: _____

_____

CONTACT NAME & PHONE #: _____

AMOUNT OF REQUEST: $ _____ **CHECK** ☐ **or METROCARD** ☐

The Below to be completed by Modivcare:

ORIGINAL DOCUMENTATION (invoice, order form, etc.) ATTACHED? YES ☐ **NO** ☐

SPECIAL INSTRUCTIONS:

Date(s) of Service: _____

Amount Verified for Reimbursement: $

Verified by: _____
Modivcare Employee

REQUESTED BY: **Arturo Paniccia- Modivcare Mass Transit Supervisor**

DIRECTOR'S APPROVAL: _____

Attach a separate *Authorization For MetroCards Log* form for each health plan submission.

- **Affinity Health Plan**
- **Amerigroup**
- **AmeriChoice by UnitedHealthcare**
- **WellCare Health Plan of NY, Inc.**

Fax information in its entirety to the attention of Arturo Paniccia at 877-457-3334.