Want your friend to give you a ride?

We'll pay for it!

At Fallon Health, we know you have places to go. And, we want to help you get there. As a member of NaviCare® HMO SNP, you can use your transportation benefit to get pre-approved rides from your friends and family. When you do, we'll cover the cost of the mileage.

Here are some examples of places you can go and be reimbursed for mileage:[1]

- Doctor's office
- Hospital
- Counseling appointments
- Pharmacy[2]
- Grocery store[3]
- Religious services[3]

What you need to do:

1. Call Coordinated Transportation Solutions (CTS) to schedule your Friends and Family ride, at least 2 days before you go. They can be reached at 1-833-824-9440 (TRS 711), 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31).
2. After you get a ride from a friend or family member, complete the form on the back of this flyer, and submit it to CTS within 60 days of your ride.
   - **For medical/behavioral health appointments, your provider must sign the back of this form.**

Important information

- The mileage reimbursement will be issued by check or direct deposit into your bank account. **You're responsible for reimbursing your friend or family member.**
- **Reimbursements will only be made per ride,** regardless of the number of eligible members in the vehicle traveling to the same or different location.
- **If you didn't pre-schedule your trip,** your reimbursement request may be denied.

1-877-700-6996 (TRS 711)

8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31)

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[1]*Mileage reimbursement is based upon the CTS mileage calculation and NaviCare allowable rate per mile.*

[2]*Your benefit includes: unlimited rides to medical/behavioral health appointments and 48 one-way rides per year to retail pharmacies. Trips to the pharmacy are limited to 4 per month and must be within a 30-mile radius.*

[3]*The 100 annual one-way rides to run errands, visit friends, attend religious services, and more, are part of a special supplemental program for the chronically ill. To qualify, enrollees must have chronic-condition diagnoses documented with Fallon Health, such as cardiovascular disorders, chronic and disabling behavioral health conditions, chronic lung disorders, diabetes, and neurologic disorders. This is not a complete list of eligible chronic conditions. Not all members with an eligible condition will qualify. Other eligibility and coverage criteria also apply.*

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Friends and Family Benefit Reimbursement Form

3 ways to get reimbursed:

1. **Mail** completed form to:
   Coordinated Transportation Solutions, Inc.
   35 Nutmeg Drive, Suite 120, Trumbull, CT 06611
2. **Email** completed form to: provider@ctstransit.com
3. **Fax** completed form to: 1-203-375-0516

Member information		
Last name	First name	
Street address		
City	State	ZIP
Mailing address *(if different from above)*		
Member ID number *(located on the front of your NaviCare ID card)*		

Activity for reimbursement *(Please enter a single 1-way trip per row, and only list rides from the same calendar month.)*

Travel date	**Address** *(Please check either Non-medical, Medical/Behavioral health, or Pharmacy.)*		
	❑ Non-medical ❑ Medical/Behavioral health ❑ Pharmacy	From	To
	❑ Non-medical ❑ Medical/Behavioral health ❑ Pharmacy	From	To
	❑ Non-medical ❑ Medical/Behavioral health ❑ Pharmacy	From	To
	❑ Non-medical ❑ Medical/Behavioral health ❑ Pharmacy	From	To

Certification and authorization *(This form must be signed and dated by the member or authorized representative.)*

Agreement:

I certify that the information above is correct to the best of my knowledge. I'm claiming reimbursement only for eligible expenses incurred during the applicable benefit year. (A benefit year is January 1 through December 31.) I attest that payments received for Friends and Family transportation will be given to the friend or family member who provided the transportation.

Member or authorized representative signature:

_____ Date: _____

Please allow 4-6 weeks from receipt of completed form for reimbursement.

To be completed and signed by your medical/behavioral health provider to verify the appointment(s) listed above. The form must be completed before your provider fills out and signs this section. *(1 form per provider/clinic.)*		
Provider name (PRINT)	Provider signature	
Street address		
City	State	ZIP