

**LOVELACE COMMUNITY HEALTH PLAN
NON-EMERGENCY TRANSPORTATION VERIFICATION FORM
MEMBER DECLARATION**

MEMBER NAME	MEMBER ID	BIRTH DATE

- I do I do not have a vehicle and I do not have anyone to transport me to my medical service provider.
- I do I do not have access to other transportation such as bus service.

I solemnly swear that the information I have given is true and accurate. I understand that any false information I provide may result in the termination of my Medicaid coverage and imposition of other civil and criminal actions as appropriate.

MEMBER OR RESPONSIBLE PARTY SIGNATURE	DATE OF TRANSPORT

ESCORT/ATTENDANT INFORMATION

OF ESCORTS TRAVELING WITH MEMBER _____ Did Attendant(s) travel with Member on all today's trips? Yes No
 If no, identify trips attendant(s) accompanied Member; _____

Name of Attendant	Relationship to Member	Signature of Attendant
Name of Attendant	Relationship to Member	Signature of Attendant
Name of Attendant	Relationship to Member	Signature of Attendant
Name of Attendant	Relationship to Member	Signature of Attendant

TRANSPORTATION PROVIDER

As the transportation provider for the above named Salud member, we confirm that we are familiar with all Lovelace Community Health Plan transportation regulations and policy requirements and they have been met,

1st pick up* Start Odometer reading _____ End Odometer reading _____ Total Miles /meter reading 1st Trip: _____	2nd pick up* Start Odometer reading _____ End Odometer reading _____ Total Miles/Meter Readings 2nd Trip: _____	3rd pick up* Start Odometer reading _____ End. Odometer reading _____ Total Miles/Meter Readings 3rd Trip- _____
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Total Miles or Meter Reading for All Trip(s) **Round miles to the nearest whole: (if .1 to .4 round down, if .5 to .9 round up to next whole number)**

MEMBER PICKED UP FROM - ADDRESS - No & Street	CITY	STATE	TIME OF PICK UP
MEMBER TRANSPORTED TO- ADDRESS - No & Street	CITY	STATE	TIME OF DROP OFF/TIME OF PICK UP
MEMBER TRANSPORTED TO - ADDRESS-No & Street	CITY	STATE	TIME OF DROP OFF

CARE-A-VAN TRANSPORTATION

(505) 397-2801

COMPANY NAME	TELEPHONE NUMBER
PO BOX 6044, 2827 N. Dal Paso, #120	88240
ADDRESS - NO & STREET	ZIP CODE
HOBBS	NM
city	STATE

SIGNATURE OF DRIVER	DATE OF SIGNATURE

I understand that any false information I provide may result in the termination of my Lovelace Community Health Plan Provider Agreement, and imposition of other civil and/or criminal actions as appropriate.

*COMPLETE A SEPARATE FORM IF: 1) MORE THAN ONE DRIVER TRANSPORTS THIS PATIENT ON THIS DATE OF SERVICE
 (2) IN THE RARE EVENT THAT MORE THAN THREE TRIPS ARE DONE IN ONE DAY FOR THIS MEMBER.*