Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ B23#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

Children insured by Medicaid have access to Medicaid provided transportation. Programs are eligible for transportation reimbursement provided to families of children not covered by Medicaid.  ***Only transportation services provided by the most economical means appropriate will be reimbursed.***

***Email this securely with any attachments to*** [***CTBirth23@ct.gov***](mailto:CTBirth23@ct.gov) ***prior to the date of service.***

|  |  |  |
| --- | --- | --- |
| **REQUEST INFORMATION** | | |
| Type of Insurance | Private | None |
| Date of Service |  | |
| Service Provided (x) | \_\_\_\_Audiological Assessment | \_\_\_\_EIS Audiological Visit |
| Service Provider(s) Name |  | |
| Service Provider(s) Discipline |  | |
| Starting Location |  | |
| Ending Location |  | |
| **TYPE OF REIMBURSEMENT REQUEST** | | |
| Mileage | Yes | No |
| Public Bus  Agency Vehicle or  Taxi/Car Service | Yes | No |

I certify that the information entered as required to reimbursement is accurate and correct to the best of my knowledge. I agree to the conditions as outlined in the Connecticut Birth to Three Payment to Programs procedure.

Name:

Signature: Date:

**FOR LEAD AGENCY USE ONLY**

The above information was verified and approved by Lead Agency:

Lead Agency Signature: Date: