

### SELF DRIVE / FFN REIMBURSEMENT FORM

FOR QUESTIONS ABOUT OR TO SCHEDULE A RIDE CALL TOLL FREE: (855) 930 7900 – Option # 1

Mid-Coast Connector  
Fiscal Department  
9 Field Street, Suite 201  
Belfast, ME 04915



**For reimbursement questions:**  
**Email:** ap@midcoastconnector.org  
**Toll free:** (855) 930 7900 (opt. 5)

**PLEASE DO NOT FAX OR EMAIL THIS FORM**  
**PLEASE PRINT CLEARLY**  
Download Self Drive Forms @ [www.midcoastconnector.org](http://www.midcoastconnector.org)

**Medical Provider Or Provider Only Completes This Section:**

I attest that the MaineCare Member listed below  
was seen by: \_\_\_\_\_  
for a MaineCare covered service on date: \_\_\_\_\_

\_\_\_\_\_  
Physician/Medical Providers Signature (**Blue Ink Only**)

**TO PREVENT PAYMENT DELAYS THIS FORM MUST BE FULLY COMPLETED BY THE MEMBER & MEDICAL PROVIDER and RECEIVED BY MIDCOAST CONNECTOR WITHIN 60 DAYS FROM THE DATE OF THE APPOINTMENT.**

MaineCare ID: \_\_\_\_\_ Full name of member: \_\_\_\_\_

**Member Information:**

Member address: *Street* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip* \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Telephone:(\_\_\_\_)-\_\_\_\_-\_\_\_\_

Date of appointment: \_\_\_\_\_ Time of appointment: \_\_\_\_\_

**Medical Provider Information:**

Name of medical provider: \_\_\_\_\_ Telephone:(\_\_\_\_)-\_\_\_\_-\_\_\_\_

Complete medical provider address: \_\_\_\_\_

**Driver Information: PER POLICY, ONLY THE DRIVER OF THE VEHICLE IS REIMBURSED**

Driver last, first name \_\_\_\_\_ *If different from member* Driver license # \_\_\_\_\_ **REQUIRED** State: \_\_\_\_\_

Driver vehicle plate # \_\_\_\_\_ **REQUIRED** Current inspection sticker  *Yes*  *No* Current insurance  *Yes*  *No*

Drivers mailing street address: \_\_\_\_\_  **Please check box if new address**

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  **Request Direct Deposit Form Be Mailed**

Reimbursement is available only for covered appointments made through and approved by Mid-Coast Connector prior to appointment. I certify the information above is accurate. I give consent to Mid-Coast Connector staff to verify the above appointment with the medical provider listed above.

Signature of MaineCare Member or responsible Adult: \_\_\_\_\_ Date: \_\_\_\_\_

All MILEAGE CALCULATIONS ARE PERFORMED USING MAP POINT SOFTWARE @ A RATE OF .22 CENTS PER MILE

*For Mid-Coast Connector office use only:*

*Date Received*

*Notes*

**SELF DRIVE/FFN REIMBURSEMENT FORM COMPLETION INSTRUCTIONS**

Revised: 5/11/16

**Note: All information entered on reimbursement forms must be legible and completed in full, or forms will be sent back to the member for follow-up. A letter from MCC will be sent detailing reason(s) for form(s) being returned.**

1. Member must enter the following information on reimbursement form **prior** to the appointment date:
  - MaineCare ID
  - Full Name & Address Of Member
  - Member's Date of Birth
  - Valid Telephone Number (must be a working telephone number)
  - Date of Appointment (will be eligible for reimbursement 60 days from this date.)
  - Time of Appointment
  - Name of Medical Provider for Appointment
  - Telephone Number of Medical Provider
  - Complete Physical Address of Medical Provider
  - Driver's Full Name
  - Driver's Complete Mailing Address
  - Valid Driver's License Number & State Where Vehicle is Registered
  - Valid Vehicle License Plate Number
  - Is there Current Inspection Sticker on Vehicle – check appropriate box
  - Is there Current Insurance on Vehicle – check appropriate box
  - For Any 7 Day Clinical Visits – Medical Dosing Sheets **must** Be Attached To Reimbursement Form

To prevent reimbursement delays, please be certain to check box on the reimbursement form if there is a new mailing address for Member or Driver. You should also contact MCC'S Intake Department at 1-855-930-7900 Option #1, to change any Member's home/mail address or telephone number. Information in our system must be accurate at all times in order for us to process reimbursements.

2. All appointments **must** be scheduled in MCC's Transportation system for reimbursement to occur. Please call MCC @ 1 (855) 930-7900 – Option #1 to schedule the trip. This must be done **prior** to the appointment date.
3. Member must return this form, signed and dated, as indicated on the bottom of form, within **60 days from the date of the scheduled appointment** or it will be considered not eligible for reimbursement.

**VERY IMPORTANT!**

4. Medical Provider must enter the following information in small box (top right corner of reimbursement form) the day of your appointment.
  - Providers Name
  - MaineCare Covered Service Date (Date of Appointment)
  - Physician/Medical Providers Signature (Members Can Not Sign)

**Medical Provider box must be fully completed. Members CANNOT fill out this box, or reimbursement will not occur. It is also considered fraud. If any areas in the medical provider box on this form are not completed or are not legible, reimbursement form will be sent back to the member for follow up. The medical provider box must be in original ink and not copied from other forms.**

5. Reimbursement Forms and Dosing Sheets must be mailed to and **received within 60 days:**

**Mid Coast Connector  
Fiscal Department  
9 Field St. – Suite 201  
Belfast, ME 04915**

**Note: Mailings with insufficient postage will be returned by the U.S. Post Office to the member, for the appropriate postage, to allow for delivery.**

6. A separate reimbursement form **must** be completed for each and every appointment. You cannot combine several appointment dates on one reimbursement form. If more than one member in vehicle, only the one driver is reimbursed.