

# SELF DRIVE / FFN REIMBURSEMENT FORM

FOR QUESTIONS ABOUT OR TO SCHEDULE A RIDE CALL TOLL FREE: (855) 930-7900 – Option # 2

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



**For reimbursement questions:**  
Email: [ap@midcoastconnector.org](mailto: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)

**Authorized MaineCare Service Provider Only Completes This Section:**

I attest that the MaineCare Member listed below was seen by  
Provider Name \_\_\_\_\_  
for a MaineCare service appointment date of: \_\_\_\_\_

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

*\*See back of form for instructions*

TO BE ELIGIBLE FOR REIMBURSEMENT THE ENTIRE FORM MUST BE FULLY COMPLETED AND RECEIVED BY MIDCOAST CONNECTOR WITHIN 60 DAYS FROM THE DATE OF THE APPOINTMENT

**Member Information:**  Please check box if any changes exist (*Member is required to call MaineCare with changes*)

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

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

Date of birth: \_\_\_\_\_ Telephone: \_\_\_\_\_ All required documents attached

**Medical Appointment - Provider Information:**

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

Name of medical provider: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

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

Driver last, first name \_\_\_\_\_ Driver Telephone Number \_\_\_\_\_  
*If different from MaineCare member listed above*

Driver license # \_\_\_\_\_ State: \_\_\_\_\_ Driver vehicle plate # \_\_\_\_\_

Current inspection sticker and Current insurance   *Yes No* Request Direct Deposit Form Be Mailed

Drivers mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  Please check box if new address

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

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

*For Mid-Coast Connector office use only:*  Utilities checked PA# \_\_\_\_\_ Leg 1 \$ \_\_\_\_\_

Comments: \_\_\_\_\_ Leg 2 \$ \_\_\_\_\_

\_\_\_\_\_ Leg 3 \$ \_\_\_\_\_

\_\_\_\_\_ Tolls \$ \_\_\_\_\_

\_\_\_\_\_ Other \$ \_\_\_\_\_

\_\_\_\_\_ Total \$ \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date Received:

Processed By:

Date:

Vendor#

Total \$

## SELF DRIVE/FFN REIMBURSEMENT FORM COMPLETION INSTRUCTIONS

Revised: 06/30/20

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

1. Member must enter the following information on the reimbursement form **prior** to the appointment date:
  - MaineCare ID
  - Full Name & Address Of Member (*Is required to match MaineCare eligibility information*)
  - 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
  - Medical Provider Name, Telephone Number and Physical Address
  - Driver's Full Name and Complete Mailing Address
  - Valid Driver 's License Number & State Where Vehicle is Registered
  - Valid Vehicle License Plate Number
  - Is there Current Inspection Sticker and Insurance on Vehicle used – check appropriate boxes
  - Indicate there is a new driver mailing address by checking the new address box
  - All Clinical Visits – Medical Dosing Sheets **must** Be Attached To the Reimbursement Form
  - Contact MCC'S Intake Department at 1 (855) 930-7900 Option #2, to change any Member's home/mail address, telephone number, or with any MaineCare changes. Information in our system must be accurate at all times in order for us to process reimbursements.
2. The driver information area is required to be entirely completed, to avoid form returns.
3. All appointments **must** be scheduled in MCC's Transportation system for reimbursement to occur, **prior** to the appointment occurring. Please call MCC @ 1 (855) 930-7900 – Option #2 to schedule or renew trips.
4. Member(s) must return this form, signed (**no photo copied signatures are allowed**) 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.
5. *Medical Providers or designated staff members only* are required to enter the following information in the small medical provider box at the top right corner of the reimbursement form, the day of your appointment. If members fill out any portion of the box, it will be deemed non eligible for reimbursement and reported as suspected fraud to the State of Maine.
  - Providers Name
  - MaineCare Covered Service Date (Date of Appointment)
  - Physician/Medical Providers Signature or designated office staff (Members Can Not Sign)
6. Self Drive reimbursement Forms and Outpatient Medication Treatment forms must be mailed together to the address below, and received within 60 days from the trip-appointment date.

**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**

7. A separate reimbursement form **must** be completed for each individual appointment. The forms are subject to be returned if separate forms aren't used.
8. Reimbursement is every two weeks. Forms must be received on the Wednesday 10 days before the pay period to be included in the upcoming payment cycle. Otherwise, reimbursement will be paid in the next payment cycle in two weeks.
9. Weekly form submissions are recommended to avoid payment delays and a consistent payment cycle.