

VIRGINIA DEPARTMENT OF HEALTH

NONEMERGENCY MEDICAL TRANSPORTATION FEE DISCLOSURE FORM

Pursuant to § 32.1-137.05:1 of the Code of Virginia

Transportation Provider Information

Provider Name: _____

Address: _____

Telephone: _____

Email/Website: _____

Transportation Information

Date of Transportation: _____

Pickup Location: _____

Destination: _____

Fees and Charges

Please identify all associated fees or other charges for which the patient will be responsible for the nonemergency medical transportation.

Base Transportation Fee: \$ _____

Mileage Charge: \$ _____

Waiting Time Fee: \$ _____

Other Fee/Charge: _____ Amount: \$ _____

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Other Fee/Charge: _____ Amount: \$ _____

Patient Financial Responsibility

Total amount for which the patient will be responsible: \$ _____

If applicable, select one of the following:

☐ No fee or charge is the responsibility of the patient.

☐ A voluntary cost share may be requested.

☐ Other: _____

Required Cost Disclosure

The total cost for transportation services disclosed on this form reflects the cost without insurance or discounted rates.

Additional Information

Notice

This form is intended to provide disclosure of fees or other charges associated with nonemergency medical transportation pursuant to § 32.1-137.05:1 of the Code of Virginia.

The applicable disclosure must be provided to the patient or the patient's representative prior to the prearrangement of nonemergency medical transportation.

Questions regarding the fees or charges disclosed on this form should be directed to the transportation provider identified above.