AUTHORIZATION FOR METROCARDS LOG
HOSPITAL – FACILITY PROGRAM

Mass Transit Supervisor
P.O. Box 464
North Haven, CT 06473
Phone: 866-684-0409 ext 226
Fax: 877-457-3334

Month_____ Year_____

Name of Health Care Facility: _____

Date of Service/ Metro Cards Distributed	No. of Metro cards Dist. For specialty visits	Medicaid ID #	DOB#	Name of member	Member signature	Check box C-child M-member E-Escort			Cash Benefit Paid	No. of cards distributed for the office visit	Total $Amount per cards
						C	M	E			
											Total $

Signature of Health Facility Personnel: _____ Date: _____

(Print Name) _____

Attach a separate *Reimbursement Request Form* for each health plan submission.

- **Affinity Health Plan**
- **Amerigroup**
- **United HealthCare Community Plan**
- **WellCare Health Plan of NY, Inc.**

Fax information in its entirety to the attention of Arturo Paniccia at 877-457-3334.