Request for Medical Trip Reimbursement Instructions

Person Receiving Medical Care:
Patients first and last name
Type of Care:
Short description of the type of care this appointment is for
Date of Travel:
Date of the appointment
Appointment Time:
Time of the appointment
Traveled From Address:
The address in which you traveled from to the appointment. If you went from home, enter your home address. If you went straight from another appointment, put the address where you had the other appointment.
To: Name and Address of Medical Provider:
The name and address of the medical provider is required here. This is necessary to verify the mileage for reimbursement.
Provider Signature:
Your medical provider must sign this form at your appointment to verify that you did in fact see them for a medical reason.
Number of Miles Traveled:
Enter the number of miles you traveled round trip in the most direct route to and from your medical appointment.
Make Payment to:
This must be completed with the name and address of whom the check for reimbursement will be payable to.
( ) check if this is an address change:
Make sure to check this box if your address has changed so we can update our system and ensure your check will be mailed to the correct address.
Signature:
Your signature is required for a request for medical trip reimbursement.
Date:
The date you signed this form is required for a request for medical trip reimbursement.

If all of this information is not completely filled out on correctly, the request will be denied and mailed back to you. You may then resubmit the form for reimbursement once it is completed correctly. Please note that all requests must be received within 60 days of the date of the medical appointment. Any trips over 60 days old will be denied.

Auxiliary aides or home visitation available for handicapped upon request.

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