Medical Transportation Reimbursement Form

Dodge County Human Services **22 6th St East Dept 401** **Mantorville, MN 55955** **Phone: 507-635-6170**	Client Name: Client PMI #: Client Address:	Driver Name: Driver Address: Relationship to Client:
Mileage Rate for Vested Interest- **V** – 20 cents per mile (e.g., self, friend, relative, neighbor) Mileage Rate for Non-Vested- **NV**- 55.5 cents per mile (e.g., volunteer, licensed Foster Parent) **Please Indicate whether the driver is Vested or Non-Vested** ☐ **Vested** ☐ **Non-Vested**	I hereby certify that I was Medical Assistance eligible during the period these expenses were incurred and that the expenses listed are accurate and eligible under the Medical Assistance Program ____________________________________ Client/Parent/Guardian/Legal Representative Signature	***Please submit a separate reimbursement form for each driver.** ***Please submit a separate reimbursement form for each individual client.**

Appointment Date/ Time	**Required Information**	**Round-trip?**
Date: Time:	Address where you were picked up: Name & Address of Facility: Signature of Person Seen:	☐ Yes ☐ No
Date: Time:	Address where you were picked up: Name & Address of Facility: Signature of Person Seen:	☐ Yes ☐ No
Date: Time:	Address where you were picked up: Name & Address of Facility: Signature of Person Seen:	☐ Yes ☐ No
Date: Time:	Address where you were picked up: Name & Address of Facility: Signature of Person Seen:	☐ Yes ☐ No
Date: Time:	Address where you were picked up: Name & Address of Facility: Signature of Person Seen:	☐ Yes ☐ No

Office Use Only			
# of Miles	Proof Provided	Parking/Other	Receipt Provided
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No

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Date: Time:	Address where you were picked up: Name & Address of Facility: Signature of Person Seen:	☐ Yes ☐ No
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	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No

______________________ ________ Signature of Authorized County Representative Date ______________________ ________ Accounting Approval Date	Provider verification of medical appointments and expenses is required to receive reimbursement. Original receipts for parking and/or meals are also required to receive reimbursement. Please attach all proofs of appointments along with parking and/or meal receipts and submit with this form.	Mileage Total: $ Parking Total: $ Meals Total: $ *This authorization must be submitted within **sixty (60) days** after the date of service to receive payment. No claim against the county will be paid, unless it is properly itemized and verified.