

Medical Transportation Reimbursement Form

Dodge County Human Services 22 6 th St East Dept 401 Mantorville, MN 55955 Phone: 507-635-6170	Client Name:	Driver Name:
	Client PMI #:	Driver Address:
	Client 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 <input type="checkbox"/> Vested <input type="checkbox"/> 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:	Address where you were picked up:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Time:	
	Name & Address of Facility:	
	Signature of Person Seen:	
Date:	Address where you were picked up:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Time:	
	Name & Address of Facility:	
	Signature of Person Seen:	
Date:	Address where you were picked up:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Time:	
	Name & Address of Facility:	
	Signature of Person Seen:	
Date:	Address where you were picked up:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Time:	
	Name & Address of Facility:	
	Signature of Person Seen:	
Date:	Address where you were picked up:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Time:	
	Name & Address of Facility:	
	Signature of Person Seen:	

<u>Office Use Only</u>			
# of Miles	Proof Provided	Parking/Other	Receipt Provided
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Appointment Date/ Time	Required Information	Round-trip?
Date:	Address where you were picked up:	<input type="checkbox"/> Yes
Time:	Name & Address of Facility:	
	Signature of Person Seen:	<input type="checkbox"/> No
Date:	Address where you were picked up:	<input type="checkbox"/> Yes
Time:	Name & Address of Facility:	
	Signature of Person Seen:	<input type="checkbox"/> No
Date:	Address where you were picked up:	<input type="checkbox"/> Yes
Time:	Name & Address of Facility:	
	Signature of Person Seen:	<input type="checkbox"/> No
Date:	Address where you were picked up:	<input type="checkbox"/> Yes
Time:	Name & Address of Facility:	
	Signature of Person Seen:	<input type="checkbox"/> No
Date:	Address where you were picked up:	<input type="checkbox"/> Yes
Time:	Name & Address of Facility:	
	Signature of Person Seen:	<input type="checkbox"/> No

<u>Office Use Only</u>			
# of Miles	Proof Provided	Parking/Other	Receipt Provided
	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes
	<input type="checkbox"/> No		<input type="checkbox"/> No
	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes
	<input type="checkbox"/> No		<input type="checkbox"/> No
	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes
	<input type="checkbox"/> No		<input type="checkbox"/> No
	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes
	<input type="checkbox"/> No		<input type="checkbox"/> No
	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes
	<input type="checkbox"/> No		<input type="checkbox"/> No

_____ Signature of Authorized County Representative	_____	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.	Mileage Total: \$		
	_____ Accounting Approval			_____	Date	Parking Total: \$
						Meals Total: \$
			Please attach all proofs of appointments along with parking and/or meal receipts and submit with this form.	*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.		