

MILEAGE REIMBURSEMENT FORM FOR GROUND TRANSPORTATION

Mail form to: 2222 Cuming Street, Omaha, NE 68102

Member Information:

Name: _____

AlohaCare Member ID Number: _____

Phone Number: _____

Driver Information:

Name: _____

Relationship to Member: _____

SSN: _____ **Telephone Number:** _____

Mailing Address: _____

Trip Date	Trip #	Medical Provider Name and Phone Number	Medical Provider's Office or Authorized Personnel Signature	Total Round Trip Miles
		Name: Phone number:		
		Name: Phone number:		
		Name: Phone number:		
		Name: Phone number:		
		Name: Phone number:		
		Name: Phone number:		

- (1) Each date of service must have a signature from the doctor's office.
- (2) We pay a rate of 50 cents per mile. Form must be received within 45 days from your date of service.
- (3) We verify appointments before making payment.
- (4) All information must be filled in for reimbursement review.

Total Amount: \$ _____

"I attest and certify that the information provided is true, correct and accurate" _____ **Member Signature and Date**

FOR INTERNAL USE

[] APP Approved - Amount: \$ _____ . _____ CSR: _____ Date: _____

[] DEN Denied *circle reason code:* INC / PRE / UNT / NEL / <\$ / OTH Notes: _____