IntelliRide by transdev

Mileage Reimbursement Verification Form (Subscription)

Please complete this form and return it to IntelliRide for reimbursement of mileage. To qualify for reimbursement, your subscription must be scheduled with IntelliRide, assigned to mileage reimbursement, and your medical provider must sign to verify your attendance.

Patient Information	First Name	Last Name	DOB	Health First Colorado ID #

Medical Facility Information	Facility Name	
	Facility Address, City, State & Zip	
	Medical Provider's Name & Title	
	Contact Name & Title	
	Contact Phone	Contact Email

Attendance Verification

With my signature, I hereby acknowledge that the above named Health First Colorado patient was seen in our office on the dates and times listed below. I certify under penalty of perjury, that the information provided is accurate to the best of my knowledge. I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both.

Date & Time	Printed Name of Facility Staff	Signature of Facility Staff
Date & Time	Printed Name of Facility Staff	Signature of Facility Staff
Date & Time	Printed Name of Facility Staff	Signature of Facility Staff
Date & Time	Printed Name of Facility Staff	Signature of Facility Staff
Date & Time	Printed Name of Facility Staff	Signature of Facility Staff
Date & Time	Printed Name of Facility Staff	Signature of Facility Staff

Driver Information	Driver's Name	Driver's Phone		
	Driver's Mailing Address	City	State	Zip

IntelliRide Use Only		
Trip Confirmation #(s):	Number of Trip Legs	Total Miles
Total Miles	Approval Status / Agent Initials	Date

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