MILEAGE REIMBURSEMENT FORM FOR GROUND TRANSPORTATION

Mail form to: PO Box 4128, Omaha, NE 68104 or Email to: us.ths.hiclaims@transdev.com.

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:___