

Mileage Reimbursement Verification Form (Subscription)

Please complete this form and return it to Transdev for reimbursement of mileage. To qualify for reimbursement, your subscription must be scheduled with Transdev, 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
Transdev Use Only				
Trip Confirmation #(s):		Number of Trip Legs		Total Miles
Total Miles		Approval Status / Agent Initials		Date