



## MILEAGE REIMBURSEMENT FORM FOR GROUND TRANSPORTATION



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

### Member Information:

Name: \_\_\_\_\_

'Ohana 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: \_\_\_\_