MA MILEAGE REIMBURSEMENT

I certify that the information on this reimbursement form is true and the expenses claimed were for MA covered services: (Signature of Client, Parent/Legal Guardian, or Representative.)

CLIENT INFORMATION

First Name: _____ Last Name: _____ Medicaid #: _____

Date of Birth: _____ Gender: _____ Phone: _____

Zip code: _____

PAYMENT INFORMATION

Name of Driver: _____

Make Payment To: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship: ◯ Self ◯ Friend ◯ Family (related) ◉ Foster Parent (not related)

TRIP LOG #1

Appointment date: _____ **Type**: ◯ Round Trip ◯ One Way

Address where you were picked up: ◯ Home ◯ Other **# Of Miles:** _____

Parking: _____

_____ **Address where you were dropped off:** **Meals:** _____

Lodging: _____

Health Care Provider Name and Address: _____

I certify that this patient was seen for a Medicaid covered health service. **Signature & Title of Healthcare Provider**

TRIP LOG #2

Appointment date: _____ **Type**: ◯ Round Trip ◯ One Way

Address where you were picked up: ◯ Home ◯ Other **# Of Miles:** _____

Parking: _____

_____ **Address where you were dropped off:** **Meals:** _____

Lodging: _____

Health Care Provider Name and Address: _____

I certify that this patient was seen for a Medicaid covered health service. **Signature & Title of Healthcare Provider**

Quality Review Signature (FSA Staff Only):

TRIP LOG #3

Appointment date:_____ **Type**: ◯ Round Trip ◯ One Way

Address where you were picked up: ◯ Home ◯ Other **# Of Miles:** _____

Parking: _____

Address where you were dropped off: **Meals:** _____

Lodging: _____

Health Care Provider Name and Address: _____

I certify that this patient was seen for a Medicaid covered health service. **Signature & Title of Healthcare Provider**

TRIP LOG #4

Appointment date:_____ **Type**: ◯ Round Trip ◯ One Way

Address where you were picked up: ◯ Home ◯ Other **# Of Miles:** _____

Parking: _____

Address where you were dropped off: **Meals:** _____

Lodging: _____

Health Care Provider Name and Address: _____

I certify that this patient was seen for a Medicaid covered health service. **Signature & Title of Healthcare Provider**

TRIP LOG #5

Appointment date:_____ **Type**: ◯ Round Trip ◯ One Way

Address where you were picked up: ◯ Home ◯ Other **# Of Miles:** _____

Parking: _____

Address where you were dropped off: **Meals:** _____

Lodging: _____

Health Care Provider Name and Address: _____

I certify that this patient was seen for a Medicaid covered health service. **Signature & Title of Healthcare Provider**

Quality Review Signature (FSA Staff Only):

Keep for your records.

INSTRUCTIONS

- Complete one reimbursement form per client.
- Submit reimbursement forms no more than 10 months past the date of the first appointment.
- The mileage forms MUST be signed by a healthcare professional at the facility to verify you attended your appointment. *This includes nurses, therapists, physician assistants, or nurse practitioner*s. It doesn't have to be the doctor.
- If you don't have a mileage form to be signed, ask your healthcare provider for a note on their facility letterhead. The note should state that you were seen and the date of the appointment. *Attach the note from your healthcare provider in place of healthcare provider signature.
- Mileage reimbursement will be paid for the shortest route available and paid to the nearest whole mile.
- Incomplete forms cannot be processed and will not be reimbursed if incorrect. The form will be returned to you to be corrected.
- Keep a copy of your mileage form for your records.
- If you are a foster parent, please check foster parent box in the Payment Information section.
- Meal reimbursement amounts: breakfast $5.50, lunch $6.50, dinner $8.00
- Mileage amounts: $.22/mile for family/friend (vested interest); current IRS rate per mile for licensed foster care reimbursement
- To get parking, meal or lodging reimbursement, your original receipt must be attached.
- A one-way trip is from your home to the appointment. A round trip is from your home to the appointment and then back home.

MAIL, FAX OR EMAIL THE COMPLETED LOGS TO:

Family Support & Assistance

MA Transportation

2117 Campus Drive SE Suite 100

Rochester, MN 55904

Fax: 507-328-7956

Email: marides@co.olmsted.mn.us

If you have questions about this form or MA Transportation, you may call 507-328-6200 or email marides@co.olmsted.mn.us