modivcare

MODIVCARE SOLUTIONS
MILEAGE REIMBURSEMENT SPENDDOWN FORM

Member First and Last Name: _____

Member Home Address: _____

City: _____ State: _____ ZIP: _____

Member Phone Number: _____ Trip Number: _____

Appointment Date _____ Appointment Time: _____ Round Trip? Yes No

Pick Up Address: _____

_____

Destination Name of Doctor/Clinic/Facility: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Doctor/Clinic/Facility Telephone Number: _____

Total Miles: _____

Gas Reimbursement Driver Name: _____

Driver Address: _____

Driver Telephone Number: _____ Relationship to Member: _____

Medical Provider's Signature: _____ Date: _____

Driver's Signature: _____ Date: _____

Return **completed** form to:
Modivcare Solutions
4149 Highline Boulevard, Suite 200
Oklahoma City, OK 73108
Fax: 1-866-355-7340

MODIVCARE SOLUTIONS WILL RETURN ALL INCOMPLETE FORMS

FOR OFFICE USE ONLY			
Medicaid Number:		Date of Birth:	
MCO:		ICN Number:	
Treatment Type:			