ROUTT COUNTY DEPARTMENT OF HUMAN SERVICES
PO Box 772790
Steamboat Springs, CO 80477
970-870-5533

MEDICAID MEDICAL MILEAGE REIMBURSEMENT FORM

Client Name: _____	**State ID#**_____	***County Use ONLY***
Client Mailing Address: _____	**Date of Birth:** _____	**Prior Authorization Given by:**
City, State, Zip: _____	**SSN:** _____	_____
		Date: _____

Vehicle Owner – Name, address, and insurance policy number (Please attach copy of insurance card – if not already on file)	Driver – Name, Address, License Number & Expiration Date (Please attach copy of Driver's License- if not already on file)

				TO BE FILLED OUT BY MEDICAL PROVIDER			Receipts required	
Appt. Date	Appt. Time	Trip originated from (address)	Destination (name & address of medical facility or doctor)	Is this a Medicaid Provided Service? Yes/No	Signature and date of Medical Provider	Roundtrip miles **COUNTY USE**	**Meals Yes/No**	**Lodging Yes/No**

Printed Name and Mailing Address of Person Receiving Reimbursement: _____ Phone: _____

_____

Signature of person receiving reimbursement: _____ Date: _____