TotalTransit

Solutions That Move You

Colorado Mileage Reimbursement Verification Form - Single Trip

Please complete this form and return it to Total Transit (fax number and address are at the bottom of the page) for reimbursement of your mileage within 14 days of your medical appointment. This trip must have been pre-scheduled.

Patient Name_____ Medicaid #_____

Date of Trip _____Appointment Time_____

Trip Confirmation Numbers _____ _____

Name of Medical Provider_____ Title_____

Medical Facility Address _____

City _____ State_____ Zip_____

Medical Facility Authorized Signer _____

Title _____ Contact Phone _____

With my signature, I hereby acknowledge that the above named Medicaid patient was seen in our office on the date and at the time identified above.

Signature _____ Date _____

Driver Information

Driver's Name_____

Contact Phone Number_____

Mailing Address _____

City _____ State _____ Zip _____

Total Transit Review

Confirmation # _____ Total Miles: _____ TT Agent: _____

Trip Count (number of unique trips/legs): _____

Total Amount: _____Date: _____

Total Transit, Inc.
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