Disabled Persons and Family Support (DPFS)
Medical Mileage Reimbursement Guidelines

DPFS allows transportation reimbursement to eligible clients for mileage to and from medical appointments related to the disability need. The DPFS programs guidelines for medical mileage reimbursement are as follows:

1. DPFS Program Staff assess the need for medical mileage reimbursement. Prior to approval, **all other resources must be exhausted, including client's ability to pay.** If a client is being reimbursed for medical transportation by another source, DPFS funds will not be utilized.

2. Mileage reimbursement rates are determined by the Division of Children and Family Services – Economic Assistance and are subject to change based on the availability of funding.

3. Transportation costs are not covered when total mileage expenditures are less than $50 per month.

4. Transportation reimbursement requests must include:
    a. Date of medical service;
    b. Actual time travel began and ended, if meals are included;
    c. Address of origin, destination and purpose of trip/travel, listing each day separately;
    d. Signature of Medical Provider on Mileage Reimbursement Form;
    e. Amounts requested for Mileage reimbursement will be verified by DPFS using an online mapping system;
    f. Signature of the adult client or parent of minor child claiming reimbursement;
        Note: Signature indicates responsibility for the accuracy of all entries, including date signed.

Mileage Reimbursement Form
ADDENDUM to CFS-22 Billing Document
Disabled Persons & Family Support Program (DPFS)

Instructions: A completed form is required for each approved medical provider and must accompany CFS-22 Billing Document to be processed for payment. Client is responsible for obtaining medical provider signature.

Client Name: _____Client ID # _____

Driver Name and Address: _____

Relationship to Client: _____

Date/Time Travel Began & Ended	Address of Origin	Purpose of Trip or Travel	Medical Provider Name	Medical Provider Address	City	State	Total Miles	Medical Provider Verification - Signature

I verify the information provided on this form is true, complete, and accurate. I understand this information may be used to verify my request for reimbursement for authorized medical mileage.

_____

Client or Authorized Representative Signature Date

Submit Mileage Reimbursement Form attached to CFS-22 Billing Document to:

Department of Health & Human Services
Division of Children & Family Services, Economic Assistance
Payment Reviewer
P.O. Box 95026
Lincoln, NE 68509-5026

DHHS only

MapQuest Verification on File for addresses listed **yes** ☐
CFS-22 Billing Document attached **yes** ☐

Total Miles: _____

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