Return To:
Traverse County Social Services
202 8th St N / PO Box 46
Wheaton, Minnesota 56296
Telephone: 320-422-7777
Fax: 320-563-4230

Due by the 5th of each Month

ONE CLIENT PER SHEET

To Be Certified By Eligibility Worker
Signed: _____
Date: _____
PrimeWest: _____Yes _____ No

REQUEST FOR MEDICAL REIMBURSEMENT

To ask for payment you must show the trip was for a necessary service covered by the Health Care program. **Each leg of the trip must be documented on separate lines. Maximum two trips per sheet**. For each trip, send us the following proofs: Appointment slip, statement from provider giving date and time of your appointment or the signature of provider on this form; parking receipts; itemized lodging receipts; and itemized meal receipts.

Trip Dates	Pick-up Times	Driver's Full Name	Who Received Medical Care	From (start of trip address)	To (name & address of medical provider or destination)	Drop-off Times	Total Miles of Each Way of Trip	Agency Use ONLY Miles x .22	Agency Use ONLY PMI
	Pick-up Time					Drop-off Time			
	Pick-up Time					Drop-off Time			
	Pick-up Time					Drop-off Time			
	Pick-up Time					Drop-off Time			

**** See page 2 for meals, lodging, parking, and insurance premiums *** ***GRAND TOTAL$_____***

I certify that I have accurately reported in this trip log the miles, dates and times I actually drove. I understand that misreporting miles driven is fraud, for which I could face criminal prosecution or civil proceedings.

DRIVER SIGN HERE: Signature: _____ (Person to get the reimbursement payment) Phone: _____
Address: _____ □ **Check box if this is a change of address**
Date: _____ Driver's License #: _____ Vehicle License Plate #: _____

The information given on this form is true and correct to the best of my knowledge and I received the reported transportation services. I understand that if I give untrue or incorrect information on purpose, I could be prosecuted for fraud. I give permission to Minnesota Health Care Programs to contact anyone I've listed for purposes of verification.

CLIENT SIGN HERE: Signature: _____ Date: _____

Date/Time of Trip	Driver's Full Name	Person Who Received Medical Care	Meal Cost	Lodging Cost	Parking Cost	Cost Effective Health Insurance	Medicare Part B Premium	Agency Use ONLY PMI

YOU MUST PROVIDE receipts for meals, lodging, and parking, except for parking meters, with the signed voucher:

A. Meals may be paid up to the following amounts: Breakfast - $5.50, Lunch - $6.50, Dinner - $8.00.
B. Lodging may be paid at actual cost, but is limited to $50.00 per night.
C. Parking fees, bus, cab and other commercial carrier fares may be paid at actual cost.
D. Mileage reimbursement may be determined by agency using mapquest.com

IF YOU CHOOSE to get medical care from a provider that is not within 30 miles for primary care and 60 miles for specialty care without a referral from your doctor, you will have to pay for your own expenses. This includes emergencies when you can get the services nearer to your home.

When another individual is needed to come with you to an appointment, this person will be reimbursed for the cost of their meals and lodging at the same standard listed above. Reimbursement may be made for more than one person if required by your physician's treatment plan. This may need to be verified, please ask your eligibility worker for details.

VOUCHER TOTAL: _____

If it is not medically necessary for a person to come with you, reimbursement for their expenses cannot be included on this voucher.

If you could reasonably eat at home, reimbursement will not be made for meals. No reimbursement for meals or lodging allowed for trips under 100 miles one-way from your home. For trips over 100 miles one-way from your home, the policy is as follows:

Breakfast reimbursement may be claimed only if you are in transit or at the medical appointment before 6:00 a.m.
Noon meal reimbursement may be claimed only if you are in transit or at the medical appointment from 11:00 AM to 1:00 PM.
Dinner reimbursement may be claimed only if you are in transit or at the medical appointment after 7:00 p.m.

Claim checks are mailed out the third Friday following the third Tuesday of every month. You will need to return the signed voucher with receipts to our agency by the 5th of every month.

Claims must be submitted so the agency receives them no later than 30 days from the date of service.

Revised and DHS approved 1/30/2020