Clay-Battelle Health Services Association

Mileage Reimbursement Program Policy Acknowledgement

1. Reimbursement can be made for trips to our facilities only for scheduled appointments.

2. You must be enrolled in our Sliding Fee Program.

3. Reimbursement will be paid at the IRS medical mileage rate. As of 1/1/2024, that rate is 21 cents per mile.

4. Patients with transportation assistance that is available through a third-party payor, such as the Medicaid Non-Emergency Medical Transport benefit, should utilize that benefit prior to requesting reimbursement under this program. Reimbursement will be limited to patient out-of-pocket costs.

5. Reimbursement will be made for one trip per vehicle per day, except when, after the first visit, the patient suffers illness or injury requiring an additional diagnosis or treatment. Reimbursement will not be made to multiple patients who travel together in one vehicle.

6. The reimbursement form must have all information included on each line. Any form without complete information will be deemed non payable and returned. Initials are not accepted in the signature space. Our staff must sign their name.

7. Only the approved reimbursement form will be accepted for payment. Alternate verification slips will not be accepted.

8. Should there be any changes in your address you must notify us immediately to update your file.

9. Payment will be made for one month at a time. Forms received after 60 days will not be accepted for payment.

10. Failure to adhere to these rules and regulations will be cause for suspension or termination from the Clay-Battelle Health Services Association Mileage Reimbursement Program.

11. The above rules and regulations have been fully explained to me. My signature indicates I understand and agree to these rules and regulations.

_____ _____

Patient Signature Date

Clay-Battelle Health Services Association

Mileage Reimbursement Form

Please list all patients with visits on this form. Patients must be a part of your household in the Sliding Fee Program.

	Name	Home Address	Date of Birth
1.			
2.			
3.			
4.			
5.			

Date	Patient #	Appointment Location	Employee Signature	Round Trip Miles

By signing, I confirm that the information above is accurate and that I incurred out-of-pocket costs in providing this transportation. If I received reimbursement for this travel from any other source, I must provide an explanation of benefits demonstrating the amount of out-of-pocket costs that remain my responsibility.

_____ _____

Patient Signature Date