

Mileage Reimbursement Voucher



PATIENT INFO			
First Name		Last Name	
Date of Birth	Medicaid #	Phone #	Voucher Code
Member/Pickup Address		City	State Zip

DRIVER INFO			
First Name		Last Name	
Driver ID	Relationship to member	Email	Phone #
Driver Address		City	State Zip

APPOINTMENT INFO			
Date	Time	Type	
Location Name		Provider Name	Provider Phone #
Provider/Dropoff Address		City	State Zip
Estimated Miles		Reimbursement Amount	

Instructions

Dear provider, please verify the information on this voucher by filling out the below and faxing the signed voucher to Alivi at **(888) 621-8962**

PROVIDER VERIFICATION			
Please sign this mileage reimbursement voucher			
Printed Name			Signature
Phone #	NPI #		

**This form must be faxed from the providers office on the day of the medical appointment.
If you have any questions, please call Alivi at (786) 441-8500**