Mileage Reimbursement Voucher

Medical Provider Phone #

**PATIENT INFO**

First Name

Last Name

Date of Birth

Health Plan ID #

Phone #

Trip ID #

Address

City

State

Zip

**DRIVER INFO**

First Name

Last Name

Driver License #

Relationship to member

Email

Phone #

Driver Address

City

State

Zip

Medical

**APPOINTMENT INFO**

Date

Time

Type

Location Name

Medical Provider Name

Medical Provider/Dropoff Address

City

State

Zip

Estimated Miles

IRS Reimbursement Rate

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **MEDICAL PROVIDER VERIFICATION**  **Dear provider, verify the information on this voucher by filling out the below and faxing the signed document to Alivi at 855-621-8962.** | | | | | |
| 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 to Alivi at 855-710-6452.**