|  |
| --- |
| **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 | Date of Birth |
|  |  |  |
| Driver License # | Relationship to member | Email | Phone # |
|  |  |  |  |
| Driver Address | City | State | Zip |
|  |  |  |  |
| **APPOINTMENT INFO** |
| Date | Time | Type | Estimated Miles |
|  |  |  |  |
| Location Name | Medical Provider Name | Medical Provider Phone |
|  |  |  |
| Medical Provider/Dropoff Address | City | State | Zip |
|  |  |  |  |
|  |
| **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 or email memberservices@alivi.com.** |
|  Printed Name |  |  Signature |  |
| Phone # |  | NPI # |  |  |

This form must be faxed or emailed from the provider’s office within 5 days. If you have any questions, please contact Alivi. *(See Mileage Reimbursement Guidelines document for phone number.)*