|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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.)*