Mileage Reimbursement Form

This form can be used to request reimbursement for driving a TCHP Member to a healthcare appointment. This form can be used for up to 5 medical appointments of mileage reimbursement from the Member's home address to a single medical facility location. MTM must receive the completed form via mail, email or fax within 30 days of the first medical appointment listed on the form. Mileage will be reimbursed at the current IRS mileage rates. Google Maps will be used to determine the distance between the from and to location. Payment will be sent to the member or documented driver within 45 days from receipt of reimbursement request.

MEMBER INFORMATION		
First Name:		Last Name:
Medicaid ID:		Date of Birth (MM/DD/YYYY):
Phone Number:	Home Address:	City:
State:	Zip Code:	Driver's Relationship to Member:

DRIVER INFORMATION		
First Name:	Last Name:	Phone Number:
Email Address:	Mailing Address:	
City:	State:	Zip Code:
Driver's License Number:	Issuing State:	Expiration Date:

TRIP INFORMATION			
Appointment Date (MM/DD/YYYY):	Appointment Time: ____ ☐ AM ☐ PM	Start Address: ☐ Home	Provider Address: ☐ RT ☐ One Way
Healthcare Provider/Facility Name:	Phone Number:	Licensed Healthcare Provider Signature:	Print Healthcare Provider Name:
Appointment Date (MM/DD/YYYY):	Appointment Time: ____ ☐ AM ☐ PM	Start Address: ☐ Home	Provider Address: ☐ RT ☐ One Way
Healthcare Provider/Facility Name:	Phone Number:	Licensed Healthcare Provider Signature:	Print Healthcare Provider Name:
Appointment Date (MM/DD/YYYY):	Appointment Time: ____ ☐ AM ☐ PM	Start Address: ☐ Home	Provider Address: ☐ RT ☐ One Way
Healthcare Provider/Facility Name:	Phone Number:	Licensed Healthcare Provider Signature:	Print Healthcare Provider Name:
Appointment Date (MM/DD/YYYY):	Appointment Time: ____ ☐ AM ☐ PM	Start Address: ☐ Home	Provider Address: ☐ RT ☐ One Way
Healthcare Provider/Facility Name:	Phone Number:	Licensed Healthcare Provider Signature:	Print Healthcare Provider Name:
Appointment Date (MM/DD/YYYY):	Appointment Time: ____ ☐ AM ☐ PM	Start Address: ☐ Home	Provider Address: ☐ RT ☐ One Way
Healthcare Provider/Facility Name:	Phone Number:	Licensed Healthcare Provider Signature:	Print Healthcare Provider Name:

Driver Attestation:

Yes or No _______ I adhere to all public laws, ordinances, and regulations applicable to drivers and the vehicles that I use

Yes or No _______ At time of transport, my drivers license was not restricted or suspended.

I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both. I declare under penalty of perjury under the laws of the United States of America and the State of Texas that the foregoing Trip Information listed above is true and correct. I hereby certify that the foregoing Trip Information is in compliance with MTM's policies and procedures.

______________________________ Driver Signature

______________ Date

______________________________ Print Driver Name

______________________________ Member Signature

______________ Date

______________________________ Print Member Name

Please submit completed forms by email, mail, or fax:

Email: txgmr@mtm-inc.net

Fax: 888-407-0936

Mail: MTM
Attn: Mileage Reimbursement
16 Hawk Ridge Circle
Lake St. Louis, MO 63367

Last updated: September 18, 2023