Mileage Reimbursement Form

This form can be used to request reimbursement for driving a HUSKY Health 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. Veyo must receive the completed form via mail, email or fax within 30 days of the first medical appointment listed on the form.

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:

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 Connecticut that the foregoing Trip Information listed above is true and correct. I hereby certify that the foregoing Trip Information is in compliance with Veyo's policies and procedures.

Driver Signature ____________________ Date ____________

Print Driver Name ____________________

Member Signature ____________________ Date ____________

Print Member Name ____________________

Please submit completed forms by email at ctmileage@veyo.com, or fax to 860-218-2948, or mail to Veyo, Attn: Mileage Reimbursement, PO Box 1070, Windsor, CT 06095

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