

Roseau County Social Service  
Medical Reimbursement Form

MAXIS OR MNSURE/METS CASE #:	DATE:
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**Client Information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of birth: \_\_\_\_\_

**Driver Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

Mode of Transportation: \_\_\_\_\_ License Plate Number of Vehicle: \_\_\_\_\_

**Odometer Start:** \_\_\_\_\_ **Odometer Stop:** \_\_\_\_\_ **Total miles:** \_\_\_\_\_

**Transport Information:**

Appointment date: \_\_\_\_\_ Time \_\_\_\_\_  A.M.  P.M.

Pick-up date: \_\_\_\_\_ Time \_\_\_\_\_  A.M.  P.M.

Pick-up location: \_\_\_\_\_

Transport to: \_\_\_\_\_ (Name of facility, agency or home)

Address: \_\_\_\_\_ (Please use *complete* address)

\_\_\_\_\_

Number of passengers \_\_\_\_\_

Passenger name or extra attendant to assist with mobility: \_\_\_\_\_

Return client to: \_\_\_\_\_

Drop-off location: \_\_\_\_\_ Time: \_\_\_\_\_  A.M.  P.M.

Is client Ambulatory (Able to walk on their own)  Yes  No

Wheelchair used?  Yes  No

*"I certify that I have accurately reported in this record the trip miles I actually drove and the dates and times I actually drove them. I understand that misreporting the miles driven and hours worked is fraud for which I could face criminal prosecution or civil proceedings."*

**Driver Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*"I certify that I received the reported transportation service."*

**Client/Authorized Rep Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*"I certify that client was seen today at our medical facility."*

**Dr/Nurse Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Agency use on back)

**AGENCY USE ONLY:**

PMI#: \_\_\_\_\_

MANAGED CARE PLAN: \_\_\_\_\_

Electronic source documentation used to calculate driving directions & mileage:

\_\_\_\_\_  
\*attach to this voucher

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*\*This document must be stapled to Roseau County Social Services voucher and turned into Accounting for payment along with any receipt(s) for food*