PriorityHealth

# TRANSPORTATION REIMBURSEMENT FORM

**ALL FIELDS MUST BE FILLED OUT COMPLETELY OR WE WILL NOT BE ABLE TO PROCESS YOUR REIMBURSEMENT**

| Medicaid Recipient's Name and Address | Contact Phone Number | Date of Birth | Medicaid ID |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

***Reimbursement can only be provided to the member's address on file with Priority Health.***
***Please submit within 90 days after your appointment.***

**Appointment Date:** _____ **Appointment Time:** _____

**City of Origin:** **Destination:**

***To be filled out by the Medical Provider***

**Name of Med. Facility:** _____

**Address and Phone #:** _____

**Name of Physician:** _____

**Type of Provider:** _____

**Purpose for Visit:** _____

**Signature:** _____ Date: _____
(Receptionist, Nurse, or Doctor Signature)

**If you, your family, neighbors, friends, relatives, etc. can provide transportation, it is expected to be provided without reimbursement. If transportation has been provided at no cost, it is reasonable to expect this to continue, except in extreme circumstances or hardship. Please explain your hardship:**

_____

_____

_____

_____

**I understand that I will be paid mileage only to the closest provider capable of providing the necessary services. I certify that the above information is correct to the best of my knowledge and the attached receipts, if any, represent eligible expenses.**

Signature: _____ Date: _____
(Recipient, parent or guardian)

**Please return to:** Priority Health Transportation Coordinator
MS1250
1231 East Beltline NE
Grand Rapids, MI 49525

**Or, Fax to:**
616.464.8905

***NOTE: As of December 2018, the reimbursement rate is $0.36 per mile. There are penalties for fraudulently submitting claims for reimbursement and misrepresentation of receipts submitted for payment.***