



# FAMILY DRIVER REIMBURSEMENT FORM

MaineCare members may use this form to claim reimbursement at \$0.21 per passenger mile effective 8/1/10 for driving to and from medical appointments. Trip authorization number must be requested in advance. Call RTP between 8am & 4pm for numbers at 774-2666 Option 4.

### STEP 1: GET THE TRIP NUMBER (S) BEFORE YOU GO

Write the trip number(s) and the date of your appointment in the space provided below. This form may be used for up to 4 round trips (for the same rider) if traveling to the same medical office in the same calendar month. Trips to different medical offices or for more than one family member must be on separate forms.

Trip # 1	[ _____ ]	Date [__/__/____]
Trip # 2	[ _____ ]	Date [__/__/____]
Trip # 3	[ _____ ]	Date [__/__/____]
Trip # 4	[ _____ ]	Date [__/__/____]

### STEP 2: RECORD THE TRIP INFORMATION

Rider Name: Last: \_\_\_\_\_ First: \_\_\_\_\_  
 Trip Origin: Street: \_\_\_\_\_ City: \_\_\_\_\_  
 Trip Destination: Street: \_\_\_\_\_ City: \_\_\_\_\_  
 Medical Office: Phys Name: \_\_\_\_\_ Facility: \_\_\_\_\_  
 Rider's Maine Care Number: [ \_\_\_\_\_ ]

### STEP 3 LOG VEHICLE ODOMETER READINGS FOR EACH TRIP (ROUND TO THE NEAREST WHOLE MILE)

	START	END	TOTAL MILES
Trip #1 FROM HOME TO MEDICAL OFFICE	_____	_____	_____
Trip #1 FROM MEDICAL OFFICE TO HOME	_____	_____	_____
Trip #2 FROM HOME TO MEDICAL OFFICE	_____	_____	_____
Trip #2 FROM MEDICAL OFFICE TO HOME	_____	_____	_____
Trip #3 FROM HOME TO MEDICAL OFFICE	_____	_____	_____
Trip #3 FROM MEDICAL OFFICE TO HOME	_____	_____	_____
Trip #4 FROM HOME TO MEDICAL OFFICE	_____	_____	_____
Trip #4 FROM MEDICAL OFFICE TO HOME	_____	_____	_____

### STEP 4: SPECIFY PAYMENT INSTRUCTIONS

A check will be sent to the Maine Care member, legal guardian, or the family member/friend who drove the vehicle.

Make Check Payable to:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Driver's Phone #: (\_\_\_\_) \_\_\_\_\_

Vendor No: F
Account                      Amount
6620.02

Check if new address

(OVER)

**STEP 5: HAVE YOUR TRIP(S) VERIFIED BY THE MEDICAL OFFICE**

**Medical Office Manager:**

Please certify that the rider named in step 2 was seen at this office for medical services on the dates listed on the front in step one. This should be completed after all appointments listed on the front.

\_\_\_\_\_  
Medical Office Signature or Stamp

\_\_\_\_\_  
Date Verified

**STEP 6: CLIENT OR GUARDIAN SIGN AND DATE CERTIFICATION**

**Certification:** I certify that I, (or the named rider), am currently eligible for Maine Care benefits and have no other means to cover the transportation. I hereby request travel reimbursement for the trip mileage logged in step 3 of this form. To the best of my knowledge, all claim information provided is correct. Mileage was recorded at times only while I, (or the named rider), was riding directly to or from the medical office. I understand that if multiple MaineCare riders are receiving transportation in the same vehicle at the same time that reimbursement can be made for only one.

\_\_\_\_\_  
Signature of Client, Parent or Guardian

\_\_\_\_\_  
Date Certified

**STEP 7: MAIL FORMS WEEKLY**

**Please submit completed forms to RTP weekly. All forms for a calendar month should be turned in by the first week of the next month. If multiple months worth of forms are submitted at one time, it may take longer to process and receive reimbursement. Thank you for your cooperation.**

**MAIL TO**

**RTP Family Driver Program  
127 Saint John Street  
Portland, ME 04102-3072**

Before mailing the claim, can you answer yes to the following?

1. Was (were) the trip authorization number(s) obtained in advance?
2. Is all information provided on this form legible and complete?
3. Are the odometer readings rounded to the nearest whole mile?
4. Is the payment information in step 4 complete, clear and correct?
5. Has the medical office verified the trips(s) and dates?
6. Has the certification been signed and dated?

Missing information, incorrect dates and/or unsigned forms will be returned for corrections prior to reimbursements being made.

If you have questions or need reimbursement claim forms, please call **774-2666 Option 4**