MI Choice Medical Transportation Reimbursement Request

➡ Submit to: UPCAP Contract Manager, PO Box 606, Escanaba, MI 49829 / Fax: (906) 786-5853

(Only **ONE** medical provider, **ONE** participant, and **ONE** transporter per form)

Section I - Participant Information & Approved Expenses: ***to be completed by UPCAP Care Manager***

Participant Name: **Ph#:** **Apt#:**

Street Address: **City:** **State:** **Zip:**

Directions to Home / Special Instns / Appt. Date & Time:

Per-Mile Rate: ❑ **Federal Rate ._____** ❑ **.17 ¢** ❑ **Attendant @ $10** **# Overnight Stays:** _____ $41.25 max w/receipt

Approved Meals: **# Breakfasts** @ $4.50 _____, **# Lunches @** $5.50 _____, **# Dinners** @ $11.75 _____

Section 2 – Medical Provider Information: ***to be completed by UPCAP Care Manager***

Medical Provider Name: **Ph#:**

Provider Street Address:

City: **State:** **Zip:**

❑ ⬅ Check if **One Time Appointment** ❑ ⬅ Check if **Ongoing Appointments** ⬇

For ongoing appointments, indicate (monthly, weekly, bi-weekly, 3X per week, etc.) **Frequency =** _____

Section 3 – Medical Transportation Information: ***to be completed by Transportation Provider***

Transportation Provider Name: **Ph#:**

Mailing Address: **Attn:**

City: **State:** **Zip:**

Section 4 – Reimbursement: ***to be completed by Transportation Provider*** ⬇ **Receipts Required** for **Lodging** only

Appt. Date	Appt. Time	Depart Time	Return Time	Medical Provider's Signature	Round Trip Miles	Rate Per Mile	Trip Cost (Miles x Rate)	Lodging	Meal Total	Other Costs Desc.	Other Costs Amount	Total

➡ **Grand Total:**

Section 5 - Signatures / Attestations of Accuracy:

Participant Signature **Date**

Care Manager Signature **Date**

Transporter Signature **Date**

My signature certifies that I provided the above service(s) and did not receive any other payment for this transportation. I am not aware that the passenger received any other payment for this transport. 3/18

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Reimbursement Form Instructions

Use one **(1) form per month** for each Medical Provider or Transporter.

Use this form for **five (5) or less trips** made in a calendar month.

Reimbursement Request forms must be submitted to UPCAP within **30 calendar days** from the last svc date.

Return Completed Reimbursement Request:

UPCAP Contract Manager, PO Box 606, Escanaba, MI 49829 - Fax: (906) 786-5853

Reimbursements are processed one (1) time per month.

Section I - Participant Information & Approved Expenses:

- **Care Managers** fill out the MI Choice Participant's Info and Approved Services *(mileage, meals, lodging)*.
- Directions/Special Instructions used to specify what door to use, assistance needed, attendant, etc.

Section 2 – Medical Provider Information:

- **Care Managers** will complete this section - only one (1) Medical Provider per form.

Section 3 – Medical Transportation Information:

- **The Transportation Provider** completes this section.
- Use only one (1) Transporter per form.
- This section will be BLANK if the Participant drives themselves.

Section 4 - Reimbursement for Driver (Volunteer, Participant, or Attendant)

- Enter all approved dates, time, and expenses.
- Has the **Medical Provider sign** EACH appointment line.

Section 5 – Signatures / Attestations of Accuracy:

- **All signatures** must be collected in order for Reimbursement to be issued.

Meals - *only when traveling out of the local area:*

- **Breakfast** (depart before 6 am & return after 8:30 am)	$4.50 (includes tax)
- **Lunch** (depart before 11:30 am & return after 2 pm)	$5.50 "
- **Dinner** (depart before 6:30 pm & return after 8 pm)	$11.75 "

Lodging: $41.25 max w/receipt (excludes tax)

Other Approved Fees: Actual

- **Approved Attendant** - *list under "Other Costs" column* $10
  (Accompanies Participant into Appointment)