Clear

MI Choice Medical Transportation Reimbursement Request

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

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 Instructions / Appt. Date & Time:

Per-Mile Rate: ☐ **Federal Rate: .59** ☐ **.30** ☐ **Attendant @ $15** **# Overnight Stays: _____**

Approved Meals: **# Breakfasts** @ $8.50 _____, **# Lunches @** $8.50 _____, **# Dinners** @ $19.00 _____ $75.00 max w/receipt

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 **All costs**

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

Section 5 - Signatures / Attestations of Accuracy: **Grand Total:**

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.

10/05/2021

MI Choice Medical Transportation Reimbursement Request

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

Reimbursement Form Instructions

Use this form for **eight (8) 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 to:

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

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. Depart/return times are required for all trips.
- Have 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:*

- For breakfast: The vehicle with the beneficiary must depart at, or before, 6:00 AM and must return at, or after, 8:30 AM./$8.50 (includes tax)
- For lunch: The vehicle with the beneficiary must depart at, or before, 11:30 AM and must return at, or after, 2:00 PM./$8.50 (includes tax)
- For dinner: The vehicle with the beneficiary must depart at, or before, 6:30 PM and must return at, or after, 8:00 PM/$19.00 (includes tax)

Lodging:	$75.00 max w/receipt (excludes tax)
Other Approved Fees:	Actual
- **Approved Attendant** - *list under "Other Costs" column* (Accompanies Participant into Appointment)	$15