Mileage Reimbursement Voucher

PATIENT INFO				
First Name		Last Name		
Date of Birth	Medicaid #	Phone #	Voucher Code	
Member/Pickup Address		City	State	Zip

DRIVER INFO				
First Name		Last Name		
Driver ID	Relationship to member	Email	Phone #	
Driver Address		City	State	Zip

APPOINTMENT INFO				
Date	Time	Type		
Location Name		Provider Name	Provider Phone #	
Provider/Dropoff Address		City	State	Zip
Estimated Miles		Reimbursement Amount		

Instructions

Dear provider, please verify the information on this voucher by filling out the below and faxing the signed voucher to Alivi at **(305) 742-2561**

PROVIDER VERIFICATION			
Please sign this mileage reimbursement voucher			
Printed Name		Signature	
Phone #	NPI #		

This form must be faxed from the providers office on the day of the medical appointment.
If you have any questions, please call Alivi at (786) 441-8500