


Des Moines Valley Health and Human Services Medical Expense Reimbursement Claim - Jackson Location
 Approved payments will be mailed after the 2nd and 4th Friday of each month. Incomplete forms may be returned delaying payment.

	Patient Name: _____ Address: _____ _____ Phone #: _____ Date of Birth: _____ PMI #: _____ <input type="checkbox"/> Check here if new address.	Payable To: _____ Address: _____ _____ Phone #: _____ <input type="checkbox"/> Check here if new address. <input type="checkbox"/> Guardian/Conservator <input type="checkbox"/> CSP Worker <input type="checkbox"/> Licensed Foster Parent <input type="checkbox"/> Non-Licensed Foster Parent
405 4th Street Bldg 4 P.O. Box 67 Jackson, MN 56143 Phone: 507-847-4000 Fax: 507-847-5616	By signing this form, I acknowledge I am obtaining services within the 30/60 rule OR if beyond, that I am using the closest provider capable of providing the level of care I need. I understand failure to do so may result in access services being denied. I give consent to DVHHS to obtain information regarding my presence or lack thereof at the medical appointments listed above. <div style="border: 1px solid black; padding: 5px; width: fit-content;"> X _____ </div>	"I Certify that I have accurately reported in this record the trip miles I actually drive and the dates and times I actually drove them. I understand that misreporting the miles driven and hours worked is fraud for which I could face criminal prosecution or civil proceedings." <div style="border: 1px solid black; padding: 5px; width: fit-content;"> X _____ </div>

(Patient Signature Required)

(Payable to Signature Required)

DATE OF SERVICE	LOCATION (CITY) OF MEDICAL PROVIDER	TOTAL MILES (ROUND TRIP)	BREAKFAST \$5.50/pers	LUNCH \$6.50/pers	DINNER \$8.00/pers	PARKING	LODGING

~Itemized Receipts and Verification of Appointments Are Required (see back)~

- A **primary care physician** must be within 30 miles of their residence. A **specialty care physician** must be within 60 miles of their residence (this includes dentists & chiropractors). If traveling beyond the 30/60 listed above, **you must contact your eligibility worker for pre-approval** in order to receive reimbursement.

- All claims for reimbursement must be made within **120 days of date of service** to be eligible for payment.

 AGENCY USE ONLY BELOW THIS LINE

Date: _____
 Approved By: _____
 MA: _____ MN Care: _____*
 Blue Plus: _____ U Care: _____
 Rate per mile: .22 _____ .72 _____**

* MN Care - provides access services for pregnant women and children up to age 21
 ** equals IRS Business Deduction rate on date of service

Total Mileage	
Total Meals	
Total Parking	
Total Lodging	
TOTAL DUE	

SIGNATURE OF MEDICAL PERSONNEL MUST VERIFY CLIENT WAS SEEN AT DATE, TIME AND LOCATION OF MEDICAL FACILITY.

DOCTOR OR OFFICE STAFF VERIFICATION

Medical personnel must complete each blank below & sign.

This is to verify that _____
(Name of Patient)
on _____ at _____ a.m./p.m.
(Date) (Time) _____ Specialist OR
_____ Primary Care
Signature _____
(Medical Personnel Signature)

What type of provider are you?
Please X one above.

was seen at _____
Street _____
City, State, Zip _____
(Name & Location of Medical Facility)
Provider Phone # _____

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Medical personnel must complete each blank below & sign.

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