

Mileage Reimbursement Form



419-423-0286

Client Name: _____ Mileage for the *Calendar* Month of: _____

Address: _____ Phone number: _____

	Date of Trip	Purpose of Trip Please Circle type of treatment	Destination	Total Miles Roundtrip	Signature of Physician or Representative
1	Jan. 10	Chemo, radiation, IV infusion, surgery, other: Please write in - EXAMPLE: LAB WORK	The Armes Family Cancer Center	20	<i>Authorized Signature</i>
2		Chemo, radiation, IV infusion, surgery, <i>other:</i> Please write in _____			
3		Chemo, radiation, IV infusion, surgery, <i>other:</i> Please write in _____			
4		Chemo, radiation, IV infusion, surgery, <i>other:</i> Please write in _____			
5		Chemo, radiation, IV infusion, surgery, <i>other:</i> Please write in _____			
6		Chemo, radiation, IV infusion, surgery, <i>other:</i> Please write in _____			
7		Chemo, radiation, IV infusion, surgery, <i>other:</i> Please write in _____			
8		Chemo, radiation, IV infusion, surgery, <i>other:</i> Please write in _____			
9		Chemo, radiation, IV infusion, surgery, <i>other:</i> Please write in _____			
10		Chemo, radiation, IV infusion, surgery, <i>other:</i> Please write in _____			
11		Chemo, radiation, IV infusion, surgery, <i>other:</i> Please write in _____			
12		Chemo, radiation, IV infusion, surgery, <i>other:</i> Please write in _____			
13		Chemo, radiation, IV infusion, surgery, <i>other:</i> Please write in _____			
14		Chemo, radiation, IV infusion, surgery, <i>other:</i> Please write in _____			
15		Chemo, radiation, IV infusion, surgery, <i>other:</i> Please write in _____			
16		Chemo, radiation, IV infusion, surgery, <i>other:</i> Please write in _____			
17		Chemo, radiation, IV infusion, surgery, <i>other:</i> Please write in _____			
18		Chemo, radiation, IV infusion, surgery, <i>other:</i> Please write in _____			

19		Chemo, radiation, IV infusion, surgery, <i>other</i> : Please write in _____			
	Date of Trip	Purpose of Trip Please Circle type of treatment	Destination	Total Miles Roundtrip	Signature of Physician or Representative
20		Chemo, radiation, IV infusion, surgery, <i>other</i> : Please write in _____			
21		Chemo, radiation, IV infusion, surgery, <i>other</i> : Please write in _____			
22		Chemo, radiation, IV infusion, surgery, <i>other</i> : Please write in _____			
23		Chemo, radiation, IV infusion, surgery, <i>other</i> : Please write in _____			
24		Chemo, radiation, IV infusion, surgery, <i>other</i> : Please write in _____			
25		Chemo, radiation, IV infusion, surgery, <i>other</i> : Please write in _____			
26		Chemo, radiation, IV infusion, surgery, <i>other</i> : Please write in _____			
27		Chemo, radiation, IV infusion, surgery, <i>other</i> : Please write in _____			
28		Chemo, radiation, IV infusion, surgery, <i>other</i> : Please write in _____			
29		Chemo, radiation, IV infusion, surgery, <i>other</i> : Please write in _____			
30		Chemo, radiation, IV infusion, surgery, <i>other</i> : Please write in _____			
31		Chemo, radiation, IV infusion, surgery, <i>other</i> : Please write in _____			
			Total		x \$0.20 = \$

A doctor or other representative must sign this form in order to receive reimbursement.

Please rate on a scale of 1 (least) to 5 (most), how much this program has assisted you and your family. Choose one:
1 2 3 4 5

Office Use Only	Client Level:	
Amount Approved:	Invoice Approved:	Date of Approval:
Current Month Amount Verified By:	Approved for Pmt:	General Ledger #: