

Form (A)

Mileage Reimbursement



CPS Phone: 419-423-0286

Please submit to CPS within the first two weeks of the following month.

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, <i>other</i> : 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	Date of Trip	Purpose of Trip Please Circle type of treatment	Destination	Total Miles Roundtrip	Signature of Physician or Representative

18	Chemo, radiation, IV infusion, surgery, <i>other</i> : Please write in _____			
19	Chemo, radiation, IV infusion, surgery, <i>other</i> : Please write in _____			
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.

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