MILEAGE REIMBURSEMENT TRIP INVOICE FORM

Mail completed form to:

Superior Medical Transportation
PO Box 6913
Albuquerque, NM 87197-6913

*****PLEASE FILL OUT A SEPARATE FORM FOR EACH PERSON TRANSPORTED*****

DRIVER NAME: ____________________ RELATIONSHIP TO MEMBER: ____________________
DRIVER MAILING ADDRESS: ____________________ DRIVER PHONE #: ____________________
DRIVER CITY/STATE/ZIP: ____________________

MEMBER NAME (if different from driver): ____________________ MOLINA HEALTHCARE of NEW MEXICO ID #: ____________________
MEMBER HOME ADDRESS: ____________________
MEMBER HOME ADDRESS (CITY/STATE/ZIP): ____________________

Voucher must be received within 30 days of the appointment, or it may be denied. If you are putting more than one appointment, you must submit the completed form within 30 days from the earliest appointment shown. Mileage reimbursement is .29 per mile.

Trip Date	Trip #	Medical Provider Name/Phone Number	Physician/Clinician Signature*	Total Miles
		Name: Phone:		
		Name: Phone:		
		Name: Phone:		
		Name: Phone:		
		Name: Phone:		

***Each date of service must have a physician or clinician signature in order for reimbursement to be approved. NOTE: Each trip will be confirmed with the physician's office before payments are made.**

I hereby certify the information contained herein is true, correct and accurate. **Driver's Signature:** ____________________

DO NOT WRITE IN THIS SPACE *Total Mileage to be Paid:*	*Total Amount of Invoice:*	*Batch #:*	*Batch Date:*