**MILEAGE REIMBURSEMENT VERIFICATION FORM**
**SINGLE TRIP**

Please complete this form and return it to Envida for reimbursement of mileage. To qualify for reimbursement, you must qualify as a Health First Colorado member, complete the mileage reimbursement form, and your medical provider must sign to verify your attendance.

| **Patient Information** | First Name | Last Name | DOB | Health First Colorado # |
|---|---|---|---|---|
| | Address | City | State | ZIP |

| **Medical Facility Information # 1** | Facility Name | NPI # | BH | Medical |
|---|---|---|---|---|
| | Facility Address, City, State & Zip | | | |
| | Medical Provider's Name & Title | | | |
| | Contact Name & Title | | | |
| | Contact Phone | Contact Email | | |

**Attendance Verification**

**With my signature, I hereby acknowledge that the above-named Health First Colorado patient was seen in our office on the dates and times listed below.** I certify under penalty of perjury, that the information provided is accurate to the best of my knowledge. I understand that if I have given false information or intentionally failed to disclose information, I may be subject to persecution, criminal, civil, or both.

| Date & Time | Printed name of Facility Staff | Signature of Facility Staff |
|---|---|---|
| | | |

| **Medical Facility Information # 2** | Facility Name | NPI # | BH | Medical |
|---|---|---|---|---|
| | Facility Address, City, State & zip | | | |
| | Medical Provider's Name & Title | | | |
| | Contact Name & Title | | | |
| | Contact Phone | Contact Email | | |

**Attendance Verification**

**With my signature, I hereby acknowledge that the above-named Health First Colorado patient was seen in our office on the dates and times listed below.** I certify under penalty of perjury, that the information provided is accurate to the best of my knowledge. I understand that if I have given false information or intentionally failed to disclose information, I may be subject to persecution, criminal, civil, or both.

| Date and Time | Printed Name of Facility Staff | Signature of Facility Staff |
|---|---|---|
| | | |

| **Driver Information** | Driver's Name | Driver's Phone | | |
|---|---|---|---|---|
| | Driver's Mailing Address | City | State | Zip |

**Envida Use Only**

| Total number of miles | Check sent |
|---|---|