Appointment verification form

You may request this form in large print or another language. Contact Customer Service toll-free at 855-321-4899 or TTY 711.

Reminders:

- Whenever possible, call for your trip at least two business days before the appointment.
- We must receive this form no later than 45 calendar days after the appointment.
- You must include all required receipts.
- We will send the funds within 14 business days of receiving this form and required receipts.

Note: You have the right to request a same-day or next-day ride. However, if your request is on short notice, and demand for rides is high, we prioritize medically urgent requests.

Please fill out the member information below.

Member name: _____

Health Share Member ID number: _____

Check the reimbursement boxes that apply to your travel.

- ☐ Mileage reimbursement: 25 cents per mile.
- ☐ Lodging reimbursement: Up to $80 per night, with some exceptions. Eligible for lodging if a) travel is outside of the service area and b) travel starts before 5 a.m. or ends after 9 p.m. **Receipts required.**
- ☐ Meal reimbursement: $11 for breakfast, $11 for lunch and $11 for dinner. Eligible for meals if a) travel is out of area (outside of Multnomah, Clackamas and Washington counties), b) travel time involves four or more hours round trip, and c) travel starts before 5 a.m, travel spans the entire period from 11:30 a.m. to 1:30 p.m., or travel ends after 9 p.m. **Receipts are not required.**

Members: Mail completed forms and required receipts to P.O. Box 301339, Portland, OR 97294

Health care providers: Include a cover sheet with clinic contact details and fax the forms to 503-296-2681

Need more copies of this form? It's available at **ridetocare.com/members**

Thank you!

RIDE to CARE

Request No. 1

Appointment date and start time:

Provider name:

Provider address:

Provider staff signature:

Appointment end time:

Request No. 2

Appointment date and start time:

Provider name:

Provider address:

Provider staff signature:

Appointment end time:

Request No. 3

Appointment date and start time:

Provider name:

Provider address:

Provider staff signature:

Appointment end time: