

**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:		
		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: