



Solutions That Move You

Colorado Mileage Reimbursement Verification Form - Single Trip

Please complete this form and return it to Total Transit (fax number and address are at the bottom of the page) for reimbursement of your mileage within 14 days of your medical appointment. This trip must have been pre-scheduled.

Patient Name _____ Health First Colorado ID # _____

Date of Trip _____ Appointment Time _____ AM PM

Trip Confirmation Numbers _____

Name of Medical Provider _____ Title _____

Medical Facility Address _____

City _____ State _____ Zip _____

Medical Facility Authorized Signer _____

Title _____ Contact Phone _____

With my signature, I hereby acknowledge that the above named Health First Colorado patient was seen in our office on the date and at the time identified above.

Signature _____ Date _____

Driver Information

Driver's Name _____

Contact Phone Number _____

Mailing Address _____

City _____ State _____ Zip _____

Total Transit Review

Confirmation # _____ Total Miles: _____ TT Agent: _____

Trip Count (number of unique trips/legs): _____

Total Amount: _____ Date: _____