APPOINTMENT VERIFICATION

Please complete and return by mail

CLIENT NAME: _____ PHONE: _____

HOME ADDRESS: _____ City _____ Zip _____

OHP+ Number: _____ DATE OF BIRTH: _____

DATE of appointment	TIME of appointment	REASON for appointment	PHYSICIAN or CLINIC NAME & ADDRESS	PHYSICIAN or CLINIC PHONE	PHYSICAN OR CLINIC SIGNATURE AND STAMP	MILEAGE to be calculated by RideLine using mapping software
	Check one: AM ☐ PM ☐				_____ Physician / Office Rep Signature date Clinic/ Physician Stamp Here	Check one: One way ☐ Round trip ☐
	Check one: AM ☐ PM ☐				_____ Physician / Office Rep Signature date Clinic/ Physician Stamp Here	Check one: One way ☐ Round trip ☐
	Check one: AM ☐ PM ☐				_____ Physician / Office Rep Signature date Clinic/ Physician Stamp Here	Check one: One way ☐ Round trip ☐

MILEAGE to be calculated by RideLine using mapping software

To be completed by RideLine:
Total mileage both pages _____

Please complete one section for each of your appointments. Have each appointment entry signed by your healthcare provider. Return the form with your healthcare providers' original signatures (no copies or faxes). To receive travel reimbursement, we must receive this form within 45 days of your appointment. Trips older than 45 days are not eligible for payment. Mail form to: CASCADES WEST RIDELINE 1400 Queen Ave SE Suite 205 Albany, OR 97322 541-924-8738

For lodging reimbursement, please attach your original lodging receipt to this form.

Client/Guardian Signature: _____ Phone: _____ Date: _____

Mailing Address (if different from home address): _____ City: _____ Zip: _____

By signing this form, you are verifying the information provided is true.

PAYEE NAME: _____

APPOINTMENT VERIFICATION

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