CANCER SERVICES
Resources. Support. Education.

505 E. Perkins Avenue
Sandusky, OH 44870
www.CancerResources.org

Phone: (419) 626-4548
Fax: (419) 502-0222
CancerServicesPatients@gmail.com

Mileage Reimbursement Form

1. A completed and signed **Cancer Services Client Intake Form** is needed for clients **BEFORE** approval of Mileage reimbursement. Clients will be notified of approval by our Patient Services Coordinator.
2. **AFTER APPROVAL from Cancer Services,** cancer patients (or authorized representatives) complete section 1 & medical providers complete section 2.
3. **Please submit** mileage reimbursement requests no later than 30 days past the first appointment indicated by fax, email, mail, or in person.
   ****Checks will be issued after reimbursement totals $20.00 or more. Checks will be mailed.**

(1) PATIENT INFORMATION:

Name of Patient: | **Date of Birth:**

Address:

City: | **Zip code:** | **County**:

(2) MEDICAL PROVIDER:

Name of Treatment Center/ Doctor:

Address:

City: | **State:** | **Zip Code:**

Phone Number:

#	Date	Name of Treatment Center	#Miles
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
		Total:	
		For Cancer Services # Of Trips: Amount reimbursed:	

A doctor or other representative must sign this form in order to receive reimbursement.

Authorized Name: Title:

Signature: Date: