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

Phone: (419) 626-4548
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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 the Patient Services Coordinator.
2. **AFTER APPROVAL from Cancer Services,** cancer patients (or authorized representative) complete Section 1 & medical provider complete Section 2.
3. **Please submit** mileage reimbursement requests no later than 30 days past first appointment indicated by fax, email, mail, or in person.

****Checks will be issued after reimbursement totals $20.00 or more. Checks are 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	Purpose of Trip	Miles Round Trip
Ex.	***1/1/2023***	***James Cancer Center, Columbus***	***Treatment, scan, surgery, other: _____***	***100***
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
			Total	

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

Authorized Name: _____ Title: _____ Phone Number: _____

Signature: _____ Date: _____

Office Use Only			
Total Trips Approved		**Amount Approved**	