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### Travel Reimbursement Request

A United Way of Erie County Partner Agency and Norwalk Area United Fund Agency

#### Travel Form – Auto

1. Patient to complete section 1
2. Medical provider to complete section 2
3. Sign and return form with receipts

**Please submit request no later than 30 days past first appointment indicated.**

#### **1. TRANSPORTATION INFORMATION:**

Name of Patient _____	Age _____	F _____	M _____
Address _____	City _____		
County _____	Zip _____	Phone _____	
Total Miles for a round trip: _____		Parking \$ _____ (Enclose parking & toll receipts)	
Total Number of Trips: _____		Turnpike Tolls \$ _____	
Please send me additional mileage forms: yes _____ no _____			

#### **2. MEDICAL PROVIDER:**

This is to verify that the above named person:

Had an appointment on \_\_\_\_\_ (date)  
 on \_\_\_\_\_ (date)  
 on \_\_\_\_\_ (date)  
 on \_\_\_\_\_ (date)  
 on \_\_\_\_\_ (date)

at: \_\_\_\_\_

(Doctor's name and place of medical provider-Example Dr. Jones at Cleveland Clinic)

Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone # \_\_\_\_\_

Authorized Name (Printed) and Title \_\_\_\_\_ Signature \_\_\_\_\_

**3.** I hereby acknowledge that the above information is true to the best of my knowledge.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_