Iowa Medicaid
Mileage Reimbursement Trip Log and Claim Form

Must be sent to: Access2Care
405 SW 5th Street, Suite C
Des Moines, IA 50309-4609
Phone: 1-844-521-9948 Fax: 1-877-645-7837

Member name:_____ Medicaid ID #:_____

Driver name (if different from Member):_____ Driver phone #:_____

Driver mailing address:_____

City/State/Zip:_____ Driver signature:_____

For repetitive trips (cancer treatment, dialysis, wound care) Physician/Clinician may sign one time for a given month. Please indicate date range in the area next to the signature block.

Trip Date	Medical Provider Name, Address, and Phone Number	Physician/Clinician Signature*		Total Miles
	Name: Address:		Repetitive trip? ☐ Yes ☐ No	
Confirmation Number	Phone #:		Dates (1 month max.)	
	Name: Address:		Repetitive trip? ☐ Yes ☐ No	
Confirmation Number	Phone #:		Dates (1 month max.)	
	Name: Address:		Repetitive trip? ☐ Yes ☐ No	
Confirmation Number	Phone #:		Dates (1 month max.)	
	Name: Address:		Repetitive trip? ☐ Yes ☐ No	
Confirmation Number	Phone #:		Dates (1 month max.)	

* Each date of service must have a provider's signature in order for reimbursement to be approved. Each trip will be confirmed with the medical provider before payment.

*****PLEASE FILL OUT A SEPARATE FORM FOR EACH PERSON TRANSPORTED*****

☐ I choose to use A2C's mileage reimbursement procedure, and I have read and understand the Mileage Reimbursement Policy. I hereby certify the information contained herein is true, correct and accurate.

Member signature:_____ **Date:**_____

A2C is unable to reimburse you if you submit an incomplete form. Drivers must submit proof of their active auto license and their auto insurance information specifying their name. A new copy of insurance information must be submitted when the insurance on file expires, but it does not need to be submitted with each form.