


**Des Moines Valley Health and Human Services Medical Expense Reimbursement Claim - Windom Location**  
 Approved payments will be mailed after the 2nd and 4th Friday of each month. Incomplete forms may be returned delaying payment.

	Patient Name: _____ Address: _____ _____ Phone #: _____ Date of Birth: _____ PMI #: _____ <input type="checkbox"/> <b>Check here if new address.</b>	Payable To: _____ Address: _____ _____ Phone #: _____ <input type="checkbox"/> <b>Check here if new address.</b>  <input type="checkbox"/> Guardian/Conservator <input type="checkbox"/> CSP Worker <input type="checkbox"/> Licensed Foster Parent <input type="checkbox"/> Non-Licensed Foster Parent
11 Fourth Street P.O. Box 9 Windom, MN 56101 Phone: 507-831-1891 Fax: 507-831-0126	By signing this form, I acknowledge I am obtaining services within the <b>30/60 rule</b> OR if beyond, that I am using the <b>closest provider</b> capable of providing the level of care I need. I understand failure to do so may result in access services being denied. I give consent to DVHHS to obtain information regarding my presence or lack thereof at the medical appointments listed above.	"I Certify that I have accurately reported in this record the trip miles I actually drive and the dates and times I actually drove them. I understand that misreporting the miles driven and hours worked is fraud for which I could face criminal prosecution or civil proceedings."
	X _____ (Patient Signature Required)	X _____ (Payable to Signature Required)

DATE OF SERVICE	LOCATION (CITY) OF MEDICAL PROVIDER	TOTAL MILES (ROUND TRIP)	BREAKFAST \$5.50/pers	LUNCH \$6.50/pers	DINNER \$8.00/pers	PARKING	LODGING

~Itemized Receipts and Verification of Appointments Are Required (see back)~

- A **primary care physician** must be within 30 miles of their residence. A **specialty care physician** must be within 60 miles of their residence (this includes dentists & chiropractors). If traveling beyond the 30/60 listed above, **you must contact your eligibility worker for pre-approval** in order to receive reimbursement.

- All claims for reimbursement must be made within **120 days of date of service** to be eligible for payment.

\_\_\_\_\_ AGENCY USE ONLY BELOW THIS LINE \_\_\_\_\_

Date: \_\_\_\_\_  
 Approved By: \_\_\_\_\_  
 MA: \_\_\_\_\_ MN Care \_\_\_\_\_\*  
 Blue Plus: \_\_\_\_\_ PrimeWest: \_\_\_\_\_  
 Rate per mile: .22 \_\_\_\_\_ .72 \_\_\_\_\_\*\*  
 RUCA 1-17 Miles x 1.25 \_\_\_\_\_ RUCA 18-50 Miles x 1.125 \_\_\_\_\_

\* MN Care - provides access services for pregnant women and children up to age 21  
 \*\* equals IRS Business Deduction rate on date of service

Total Mileage	
Total Meals	
Total Parking	
Total Lodging	
<b>TOTAL DUE</b>	

**SIGNATURE OF MEDICAL PERSONNEL MUST VERIFY CLIENT WAS SEEN AT DATE, TIME AND LOCATION OF MEDICAL FACILITY.**

**DOCTOR OR OFFICE STAFF VERIFICATION**

*Medical personnel must complete each blank below & sign.*

This is to verify that \_\_\_\_\_  
(Name of Patient)  
on \_\_\_\_\_ at \_\_\_\_\_ a.m./p.m.  
(Date) (Time) \_\_\_\_\_ Specialist OR  
\_\_\_\_\_ Primary Care  
Signature \_\_\_\_\_  
(Medical Personnel Signature) **What type of provider are you?**  
Please X one above.

was seen at \_\_\_\_\_  
Street \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
(Name & Location of Medical Facility)  
Provider Phone # \_\_\_\_\_

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on \_\_\_\_\_ at \_\_\_\_\_ a.m./p.m.  
(Date) (Time) \_\_\_\_\_ Specialist OR  
\_\_\_\_\_ Primary Care  
Signature \_\_\_\_\_  
(Medical Personnel Signature) **What type of provider are you?**  
Please X one above.

was seen at \_\_\_\_\_  
Street \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
(Name & Location of Medical Facility)  
Provider Phone # \_\_\_\_\_

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