Des Moines Valley Health and Human Services Medical Expense Reimbursement Claim - Jackson Location

Approved payments will be mailed after the 2nd and 4th Friday of each month. Incomplete forms may be returned delaying payment.

407 5th Street
P.O. Box 67
Jackson, MN 56143
Phone: 507-847-4000
Fax: 507-847-5616

Patient Name: _____
Address: _____
_____
Phone #: _____
Date of Birth: _____
PMI #: _____
☐ **Check here if new address.**

*By signing this form, I acknowledge I am obtaining services within the **30/60 rule** OR if beyond, that I am using the **closest provider** 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 therof at the medical appointments listed above.*

X _____

(Patient Signature Required)

Payable To: _____
Address: _____
_____
Phone #: _____
☐ **Check here if new address.**

☐ Guardian/Conservator ☐ CSP Worker
☐ Licensed Foster Parent ☐ Non-Licensed Foster Parent

"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 _____

(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: _____ U Care: _____
Rate per mile: .22 _____ .67_____**

* 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	
TOTAL DUE	

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 _____ was seen at _____
(Name of Patient)
Street _____
on _____ at _____ a.m./p.m. City, State, Zip _____
(Date) (Time) _____ Specialist OR (Name & Location of Medical Facility)
_____ Primary Care
Signature _____ **What type of provider are you?** Provider Phone # _____
(Medical Personnel Signature) **Please X one above.**

DOCTOR OR OFFICE STAFF VERIFICATION

Medical personnel must complete each blank below & sign.

This is to verify that _____ was seen at _____
(Name of Patient)
Street _____
on _____ at _____ a.m./p.m. City, State, Zip _____
(Date) (Time) _____ Specialist OR (Name & Location of Medical Facility)
_____ Primary Care
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(Medical Personnel Signature) **Please X one above.**