DHS-3261-ENG 1-08

Date: ______

Fill in: Case number: ✱ ______

Worker name: ______

Worker phone number: ______

Fax number: ______

Agency name: ______

Agency address: ______

Minnesota Health Care Programs
Expense Reimbursement Form

If you are pregnant or are under age 21, you **may** get reimbursed for transportation, parking, meals, lodging and child care for you and your child's medical appointments. **Use one form per person.**

What do I have to do?

Save your receipts for the expenses listed above. Then fill out this form and send it with your receipts.

In the section below, write:

- The name and date of birth of the person who had the medical appointment. If two people had a medical appointment during the same trip, only write one person's name.
- The date(s) of the medical appointment(s).
- The cost of services, such as transportation or parking, that you needed on that date.
- Ask the medical provider to fill out the back of the form for each visit.
- **You must sign the back of each form.**
- Send completed form to your worker. Mail to MnCare PO Box 64838 St. Paul 55164-0838
- You must complete and sign the "check payable section" on the bottom of page 2.

Reimbursement

We will reimburse the person who paid for the services. If you paid for all the services, one check will be sent to you. If someone else paid for a service, write that person's/company's name, Social Security number or Tax ID number, address, and amount paid on a separate piece of paper and attach it to this form.

Appeals

You have the right to appeal the decision if your request for reimbursement is denied. You must ask for an appeal hearing within 30 days (or 90 days if you have a good reason for the delay). If you want a hearing, contact:

Minnesota Department of Human Services
Appeals and Regulations
P.O. Box 64941
St. Paul, MN 55164-0941

Complete this Section

NAME OF PERSON WHO HAD THE MEDICAL APPOINTMENT	DATE OF BIRTH

Date of Service		Car Transportation		Other Transportation		Parking	Meals	Lodging	Child Care – Appeals only		Cost
To	From	Miles	Cost*	Code below**	Cost	Cost	Cost	Cost	Hrs @ $__/hr	Cost	Total Each Row
			$		$	$	$	$		$	$
			$		$	$	$	$		$	$
			$		$	$	$	$		$	$
			$		$	$	$	$		$	$
			$		$	$	$	$		$	$
			$		$	$	$	$		$	$
			$		$	$	$	$		$	$
			$		$	$	$	$		$	$
			$		$	$	$	$		$	$
										Total all costs	$

* 20¢/mile if you or a family member drove; 50.5¢/mile if someone else used his or her car to drive you or your child.
** Transportation Codes: B=Bus, T=Taxi, O=Other

Ask your medical provider or hearing examiner to complete the following

1. NAME OF PERSON GETTING SERVICE		DATE OF SERVICE(S) OR HEARING
THIS PERSON WAS SEEN ON THE ABOVE DATE ☐ YES ☐ NO	THE SERVICE WAS COVERED OR REIMBURSABLE UNDER THE PATIENT'S HEALTH PLAN ☐ YES ☐ NO	
PROVIDER/EXAMINER NAME		
SIGNATURE	TITLE	PHONE
2. NAME OF PERSON GETTING SERVICE		DATE OF SERVICE(S) OR HEARING
THIS PERSON WAS SEEN ON THE ABOVE DATE ☐ YES ☐ NO	THE SERVICE WAS COVERED OR REIMBURSABLE UNDER THE PATIENT'S HEALTH PLAN ☐ YES ☐ NO	
PROVIDER/EXAMINER NAME		
SIGNATURE	TITLE	PHONE
3. NAME OF PERSON GETTING SERVICE		DATE OF SERVICE(S) OR HEARING
THIS PERSON WAS SEEN ON THE ABOVE DATE ☐ YES ☐ NO	THE SERVICE WAS COVERED OR REIMBURSABLE UNDER THE PATIENT'S HEALTH PLAN ☐ YES ☐ NO	
PROVIDER/EXAMINER NAME		
SIGNATURE	TITLE	PHONE
4. NAME OF PERSON GETTING SERVICE		DATE OF SERVICE(S) OR HEARING
THIS PERSON WAS SEEN ON THE ABOVE DATE ☐ YES ☐ NO	THE SERVICE WAS COVERED OR REIMBURSABLE UNDER THE PATIENT'S HEALTH PLAN ☐ YES ☐ NO	
PROVIDER/EXAMINER NAME		
SIGNATURE	TITLE	PHONE

Make check payable to

NAME	SOCIAL SECURITY NUMBER/TAX ID NUMBER	AMOUNT $
ADDRESS		

To the best of my knowledge the information provided on this form is true and correct. I understand that if I intentionally provide information that is later found to be false or incorrect, I could be prosecuted for fraud. I authorize Minnesota Health Care Programs to contact anyone I've listed for purposes of verification. My health plan or other insurance does not cover these services.

PLEASE SIGN BELOW

SIGNATURE	PHONE NUMBER	DATE	CASE NUMBER

This information is available in other forms to people with disabilities by contacting us at (651) 431-2670 (voice), or toll free at (800) 657-3739. TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.