CHAMPION HEALTH PLAN

Routine Transportation Reimbursement Form
Plan Approved Locations

Trips must be to or from plan-approved locations, such as network providers, medical facilities, pharmacies, or hearing and vision appointments. If a member is privately transported to dialysis service appointments (not using our transportation benefit), the private driver may be reimbursed by our plan at $0.60 per mile.

MEMBER INFORMATION

Member Name:			
Member ID:		**Date of Birth:**	
Member Address:	**Number & Street:**		
	Apt. #:		
	City:		
	Zip Code:		
Member Telephone Number:			

DRIVER INFORMATION

Name:	
Telephone Number:	
Relationship to Member:	

(CHOOSE EITHER “Check” OR “ACH”)

Check: ☐ **(mailed to above Member Address)**	**ACH:** ☐ **(Automatic Bank Payment)**	**Member:** ☐	**Driver:** ☐
Bank Routing #:			
Bank Account #:			

CHAMPION HEALTH PLAN

Date	Time	One-Way	Round Trip	Starting Address (Full Address)	Site Location Address (Full Address)	Purpose (i.e. Doctor, Drug Store, etc.)	Amount Paid (Proof of Payment Required)	Driver Info: S = Self C = Caregiver/Private G = County Operated O = Other (Describe)
		☐	☐					
		☐	☐					
		☐	☐					
		☐	☐					
		☐	☐					
		☐	☐					
		☐	☐					

Member (Representative) Signature

Date