

## Mileage Reimbursement Program

**IMPORTANT: To join the Reimbursement Program and determine eligibility please contact Ride Line at 541.924.8738 or Toll Free at 866.724.2975 Monday – Friday, 8:00 am to 5:00 pm.**

The Program offers travel reimbursement for eligible Oregon Health Plan Plus (OHP+) and InterCommunity Health Network (IHN) clients within Benton, Linn, and Lincoln counties, traveling to and from eligible medical services.

### **ALL ELIGIBLE TRIPS MUST BE CALLED IN TO RIDE LINE BEFORE THE APPOINTMENT OR THE SAME DAY OF THE APPOINTMENT.**

Trips not priorly called in or “pre-authorized” are not eligible for reimbursement except for afterhours emergency appointments or urgent care. These must be called in to Ride Line no later than the next business day after the appointment, in order to be eligible for reimbursement.

**\*Ride Line is available Monday through Friday 8:00 am to 5:00 pm.**

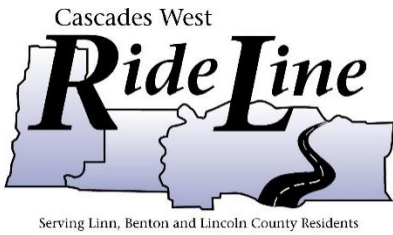
Reimbursement payments are made electronically to a prepaid debit card, the U.S. Bank ReliaCard®. Once funds are added to the card account, it can be used to make purchases, pay bills, and make online, phone or mail-order purchases. You can also get cash back with purchases at participating merchants or withdraw cash at ATMs, banks, or credit unions. The reimbursement funds can be spent however you choose. **\*This card can be ordered by calling Ride Line.**

**An Appointment Verification Form will need to be signed by the doctor’s office or facility for each appointment being requested for reimbursement.** Printable forms are available online at [www.ocwcog.org](http://www.ocwcog.org) or by contacting Ride Line.

**A Ride Line staff member would be happy to go over more details on the Mileage Reimbursement Program and other medical transportation services we offer.**

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**AUTHORIZATION FOR MILEAGE REIMBURSEMENT  
CLIENT / DESIGNATED PAYEE**

Mileage reimbursement is generally issued to the client, or if the client is a minor, the head of the household on the case.

If reimbursement is intended for someone other than the client, written approval must be obtained from the client before authorizing reimbursement

Date: \_\_\_\_\_ Client Name: \_\_\_\_\_  
(Please Print)

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Client Street Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Client Mailing Address (if different): \_\_\_\_\_

Client Phone: \_\_\_\_\_

I authorize \_\_\_\_\_ to receive my travel reimbursement.  
(Please Print)

Client Signature: \_\_\_\_\_

When payee is other than client, the following information is needed:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Payee Signature: \_\_\_\_\_

**ONLY original form accepted. Copies, faxes or emails will not be accepted.  
Debit cards will not be ordered without complete information & signature(s).**

