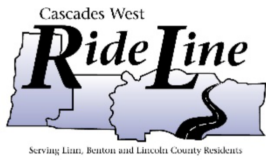

APPOINTMENT VERIFICATION

Please complete and return by mail

OHP+ Number: ____________________

CLIENT NAME: ____________________ **ONLY ONE NAME PER FORM**

HOME ADDRESS: ____________________ City ________ Zip ________

PHONE: ____________________ DATE OF BIRTH: ____________________

BLACK OR BLUE INK ONLY

DATE of appointment	TIME of appointment	REASON for appointment	PHYSICIAN/CLINIC NAME ***AND*** OFFICE ADDRESS	PHYSICIAN or CLINIC PHONE	PHYSICAN OR CLINIC SIGNATURE AND STAMP	MILEAGE to be calculated by Ride Line using state approved software
	Check one: AM PM				____________________ Physician / Office Rep Signature date Clinic/ Physician Stamp Here	Check one: One way Round trip
	Check one: AM PM				____________________ Physician / Office Rep Signature date Clinic/ Physician Stamp Here	Check one: One way Round trip
	Check one: AM PM				____________________ Physician / Office Rep Signature date Clinic/ Physician Stamp Here	Check one: One way Round trip

MILEAGE to be calculated by Ride Line using state approved mapping software

To be completed by RideLine:
Total mileage both pages ________

***All trips must be called in prior to the appointment*. Please completely fill out the form to be eligible for reimbursement. Have each appointment entry signed and dated by your healthcare provider and return the form when completed. To receive travel reimbursement, we must receive this form within 45 days of your appointment. Trips older than 45 days are not eligible for payment. Mail or drop off your completed form to: CASCADES WEST RIDE LINE 1400 Queen Ave SE Suite 205 Albany, OR 97322 or email it to rideline@ocwcog.org. For questions, or to schedule a trip, please call 541-924-8738 or Toll Free 1-866-724-2975.**

For lodging reimbursement with prior approval, please attach your original lodging receipt to this form.

Client/Guardian Signature: ______________________________ Phone: ________________ Date: ________________

Mailing Address (if different from home address): ______________________________ City: ________________ Zip: ____________

By signing this form, you are verifying the information provided is true.

PAYEE NAME: ______________________________

APPOINTMENT VERIFICATION

DATE of appointment	TIME of appointment	REASON for appointment	PHYSICIAN/CLINIC NAME ***AND*** OFFICE ADDRESS	PHYSICIAN or CLINIC PHONE	PHYSICAN OR CLINIC SIGNATURE AND STAMP	MILEAGE to be calculated by Ride Line using state software.
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