Oklahoma Health Care Authority

Oklahoma Health Care Authority
Self-Directed Services
Mileage Reimbursement Request Form

Employee name: ______________________ **Member name:** ________________________

Date	Destination	Total miles to and from destination	Total amount (.50 per mile)

***Mileage reimbursement can not be claimed for the following:**

1. To and from day services.
2. To and from supportive and competitive employment.
3. Transporting school-aged children to and from school.

****Employee must have current automobile insurance. Vehicles used to transport members must have seat belts and must be used by the member at all times. Each vehicle must have first aid supplies.**

****Inaccurate or incomplete documentation will be returned for correction, which may result in delay of payments.**

Employee signature:_________________________ **Date:**________________

Employer or member signature:_________________________ **Date:**_____________

For OHCA Approval mail or fax to:
Attn: Long Term Care Administration
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105
Phone: 888-287-2443
Fax: 405-530-7265

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