Client Expense Reimbursement Form

300 East St. Germain Street – Suite 220
St. Cloud, MN 56304
320-257-3036   320-257-3038 fax

For office use

Amount ___________________________

Date rcvd _________________________

Documentation included____________

Entered services ___________________

MCM contacted ___________________

Name ____

Address ____

New address – check here_____

Mileage ($0.35 per mile)

Date	Number of Miles	Amount to Reimburse	Purpose of Trip	Destination City	Accounting Code (For accounting use only)
Total					

Other Expenses (attach receipts)

Date	Amount	Type of Expense	Accounting Code (For accounting use only)
Total			

By signing this form, I certify that my statements are true and correct and that I am not requesting reimbursement from another source for the trips listed above. RAAN must be the payer of last resort when requesting reimbursement. Further, I understand that receiving reimbursement from multiple sources for the same trip or expenses is cause to be discharged from RAAN's Transportation Program. **Lack of proper documentation or incomplete information will delay your payment. REMEMBER TO SIGN BELOW – We cannot reimburse without your signature**

Client/Volunteer Signature ________________________ Date ________ Bus Mgr Signature ____________ Date ______

Updated 10/19/11

DIRECTIONS FOR COMPLETING THIS FORM

To receive reimbursement for mileage or expenses incurred in order to access medical, dental, mental health care, pharmacy, or other HIV/AIDS supportive services, complete this form and return it to the RAAN office.

Mileage

- It is necessary for you to complete all sections except the "Accounting Code" section, which will be completed by RAAN.
- Mileage is reimbursed at $0.35 per mile. Indicate on the form the number of miles traveled for each trip, then calculate the reimbursement by multiplying the number of miles traveled by $0.35.
- Please provide as much identifying information under "Purpose of Trip" as possible, including the name of the clinic or site visited. **Documentation of visit is required including at least one of the following: appointment card, medical bill, co-pay receipt or sign off by your case manager.** Sample Documentation is available on request.

Other Expenses

- All other expenses require approval from RAAN prior to the expense being incurred.

RAAN will be unable to reimburse your expenses or mileage until adequate information on the purpose of your trip is provided. If you have questions or need help, please call 800-966-9735, Option 2 – Transportation Coordinator. Please note that expense reports must be submitted timely. We may not be able to reimburse late requests (greater than 3 months after the trips were taken)

RECEIPTS/PROOF OF VISIT MUST BE ATTACHED IN ORDER FOR RAAN TO REIMBURSE YOUR EXPENSES.

Mail or fax this form to: **RAAN – 300 East St. Germain Street – Suite 220- St. Cloud, MN 56304**
Fax: 320-257-3038

*****Reminder *****

Completed form and proper documentation needs to be in RAAN office by 6th of the month for your check to be mailed that same month. Checks are mailed on the 24th of the month for requests made by the 6th.

All required documentation for participation in RAAN programs must be current to receive reimbursement. This includes but is not limited to, current verification of income, insurance or physician appointments. Payment will be withheld until documentation is provided by you. RAAN must be payer of last resort when requesting reimbursement.
Contact your medical case manager if you have questions.

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