Priority Health

Mileage reimbursement form

This form allows you to submit a mileage reimbursement request.

Please submit this form within 90 days after your ride. All fields must be filled out completely or we will not be able to process your reimbursement. You can also log in to your member account at ***member.priorityhealth.com*** to complete and submit a digital version of this form.

How do I submit this form?

Mail:
Priority Health Transportation Coordinator
MS 1250
1231 East Beltline Ave NE
Grand Rapids, MI 49525

Email:
reimbursement@priorityhealth.com

Fax:
616.464.8905

What if I have questions?

Call us at **888.975.8102**. We're available Monday through Thursday from 8:30 a.m. to 5 p.m. and Friday from 9 a.m. to 5 p.m. Select option 1 and enter your member ID number. Once you're done following the prompts, select option 2 for transportation.

1. Member information		
First name	Last name	Priority Health ID number

2. Members in foster care or temporary guardianship (if applicable)
Are you a minor in foster care or in temporary guardianship and would like the reimbursement sent to your foster parent or temporary guardian? ☐ Yes *(complete section 2a.)* ☐ No

2a. Foster parent or temporary guardian information		
First name	Last name	M.I.
Date of birth ____/____/_____	Priority Health ID number (if applicable)	
Street address		Unit/apt./lot no.
City	State	Zip Code
Phone ( ) -	Fax (if applicable) ( ) -	Email

3. Ride details

Ride 1		
Date ____/____/_____	Time	Destination
Street address		Unit/apt./lot no.
City	State	Zip Code

Ride 2		
Date ____/____/_____	Time	Destination
Street address		Unit/apt./lot no.
City	State	Zip Code

Ride 3		
Date ____/____/_____	Time	Destination
Street address		Unit/apt./lot no.
City	State	Zip Code

4. Signature

I understand if my family, neighbors, friends, relatives, or myself etc. can provide transportation, it is expected to be provided without reimbursement. If transportation has been provided at no cost, it is reasonable to expect this to continue, except in extreme circumstances or hardship. I understand that I will be paid mileage only to the closest location capable of providing the necessary services. I understand there are penalties for fraudulently submitting claims for reimbursement and misrepresentation of receipts submitted for payment. I certify that the above information is correct to the best of my knowledge and the attached receipts, if any, represent eligible expenses.

Signature	Today's date ____/____/_____

Priority Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia en su idioma. Consulte al número de Servicio al Cliente que está en la parte de atrás de su tarjeta de identificación de miembro. (TTY: 711).

ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. يرجى الاتصال برقم خدمة العملاء على الجانب الخلفي من بطاقة عضويتك الشخصية. (رقم هاتف الصم والبكم: 711).