



## Michigan Meals and Lodging Claim Form

This form must be completed for each trip requiring meal and/or lodging reimbursement. All meals and lodging must be booked at least 3 calendar days prior to the date of service. Claim forms with incomplete information will not be reimbursed until all required information is received. Receipts are required for all meals and lodging expenses. Lodging information is only required when Member chooses to make their own lodging arrangements. Reimbursement amounts are specified in the Michigan Medicaid Meals and Lodging Reimbursement Policy. Submit claim form within 12 months from date of service. For information, go to [saferidehealth.com/molina-mi](http://saferidehealth.com/molina-mi).

### Member/Trip Information

Medicaid ID #: \_\_\_\_\_  
Member Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State, Zip: \_\_\_\_\_  
Appointment Date/Time: \_\_\_\_\_  
Attendant Name: \_\_\_\_\_

### Lodging Information

Lodging Ride ID #: \_\_\_\_\_  
Start & End Date: \_\_\_\_\_  
Lodging Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State, Zip: \_\_\_\_\_  
Cost per night: \_\_\_\_\_

### Medical Provider Information

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State, Zip: \_\_\_\_\_

### Meal Information

Meal Ride ID #: \_\_\_\_\_

|            | Count | Cost  |
|------------|-------|-------|
| Breakfast: | _____ | _____ |
| Lunch:     | _____ | _____ |
| Dinner:    | _____ | _____ |

**Reimbursement Rates: Lodging:** \$75.00 per day; Medicaid will reimburse at the lower general public rate. **Meals:** Breakfast \$8.50; Lunch \$8.50; Dinner \$19.00.

Is the member seeking reimbursement after services have been completed?

☐ Yes ☐ No ☐ N/A

Are receipts attached? ☐ Yes ☐ No ☐ N/A

If yes, select: ☐ Meals ☐ Lodging ☐ Both

### Level of Service

☐ **Mileage Reimbursement:** The driver/caller must attest to all requirements below. If the driver or member cannot attest to every credentialing item, SafeRide cannot schedule mileage reimbursement.

1. The driver is not excluded from participating in any federal health care program and is not listed on the exclusion list of the Office of Inspector General, U.S. Department of Health and Human Services.
2. The driver has a valid driver's license.
3. The driver has no state drug or alcohol violations and is not currently under the influence of drugs or alcohol.
4. The driver has no more than two moving violations within the past two years and has no Operating While Intoxicated (OWI) or Driving Under the Influence (DUI) conviction(s).

☐ **Ambulatory:** Member can walk or transfer into an unmodified vehicle.

☐ **Ambulatory—Door-to-Door Assistance:** Member can walk but may need door-to-door assistance.

☐ **Ambulatory—Modified Vehicle:** Member can walk or transfer into a modified vehicle (for example, bariatric). Please provide details below.

☐ **Wheelchair:** Member cannot walk or transfer into a car, is confined to a wheelchair, and requires a lift-equipped wheelchair van.

Member Hospitalized? ☐ Yes ☐ No Period of Time? \_\_\_\_\_

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_ (Molina Case Managers not required to get member signature)

To be completed by Medical Provider or their staff only (This section below is not required to be filled out by Molina Case Managers)

By signing below, I verify that the Member's condition and/or treatment requires them (and attendant, if applicable) to incur additional meals and/or overnight lodging expenses.

Physician/Medical Provider Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Print) (Signature)

Michigan Medicaid Provider # NPI: \_\_\_\_\_

I certify that the above-named member's medical conditions require an attendant to accompany them during their appointments. \_\_\_\_\_ (Signature)

SafeRide Approval Status: ☐ Approved ☐ Not Approved ☐ Pending Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Please complete and return to: [molina\\_travel@saferidehealth.com](mailto:molina_travel@saferidehealth.com)

If you have questions, call 833-944-0517 during normal business hours.

CAD\_5198201\_ENG\_State Approved  
10292025 ©Molina 2026

5198201\_MI5CADFRMENG\_M\_0MI