

# SafeRide Health

## Michigan Meals and Lodging Claim Form

This form must be completed for each trip requiring meal and/or lodging reimbursement. 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.

Please submit claim form within 90 days from date of service.

For more information, go to [www.saferidehealth.com/meridian](http://www.saferidehealth.com/meridian)

### Member/Trip Information

Medicaid ID #: \_\_\_\_\_  
Member Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State, Zip: \_\_\_\_\_  
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:	_____	_____

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

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### To be completed by Medical Provider or their staff:

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: \_\_\_\_\_ Other: \_\_\_\_\_

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

\_\_\_\_\_  
(Signature)

Please complete and return to: [meridian\\_travel@saferidehealth.com](mailto:meridian_travel@saferidehealth.com)  
If you have questions, call (833) 944-0517 during normal business hours.