SafeRide Health

KanCare | sunflower health plan

Sunflower Medicaid 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 KanCare Medicaid Meals and Lodging Reimbursement Policy.

Please submit claim form within 60 days from date of service.

Member/Trip Information

Medicaid ID #: ______________________

Member Name: ______________________

Phone: ______________________

Address: ______________________

City: ______________________

State, Zip: ______________________

Attendant Name: ______________________

Email: ______________________

(An email is required in order to receive payment through Interchecks.com)

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)

Sunflower 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: sunflower_travel@saferidehealth.com.
If you have questions, call (833) 944-0517 during normal business hours.

KDHE-Approved 10/8/2024