SafeRide Health

United Healthcare Community Plan

KanCare

UnitedHealthcare 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 (Email required to receive payment through PayQuicker)

Lodging Information

Lodging Ride ID #
Check In Date
Check Out Date
Lodging Name
Phone
Address
City
State, Zip
Cost per night

Medical Provider Information

Name		
Phone		
Address		
City		
State, Zip		
Member Hospitalized?	Yes ☐	No ☐

Meal Information

Meal Ride ID#		
	Count	Cost
Breakfast		
Lunch		
Dinner		
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: _____

Medicaid Provider # NPI:_____ Other:_____

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

Signature: _____ Date: _____

Please complete and return to: united_travel@saferidehealth.com

If you have questions, call toll free 1-877-542-9238 during normal business hours.