SafeRide Claims Department
18302 Talavera Ridge
Ste 300
San Antonio, TX 78257

KANSAS MILEAGE REIMBURSEMENT LOG

Driver Name: _____ Relationship to Member: _____

Driver Mailing Address: _____ Driver Phone #: _____

City/State/Zip: _____

Member Name *(If Different from Driver)* _____ Member ID#: _____

Trip date	Trip/Job #	Medical Provider Name & Phone #	Physician/Clinician Signature*	Total Miles
		Name: Phone #:		
		Name: Phone #:		
		Name: Phone #:		
		Name: Phone #:		
		Name: Phone #:		
		Name: Phone #:		

*Each date of service must have a physician or clinician signature in order for reimbursement to be approved. Each trip will be confirmed with the physician's office before payments will be made.

Email it to uhc_claims@saferidehealth.com or fax to 1-888-453-5398.

I hereby certify the information contained herein is true, correct and accurate.

Signature: _____