

MILEAGE REIMBURSEMENT FORM

Cancer Association of Auglaize County
506 Jackson St, St Marys OH 45885
419-300-3556 (phone) 419-300-7239 (fax)
A Proud Member of the United Way of Auglaize County

(If using PO Box to receive mail, please also put actual street address) Drivers Name: Phone Number: Date: Certified by: Date: (Signature of attendant, nurse or doctor) Date received Date reimbursed Amount reimbursed Total mileage Check Number Amount reimbursed USE ONLY DATE TREATMENT CENTER NAME & COMPLETE ADDRESS Example 4/1/XX James Cancer Center, 460 W 10th Ave, Columbus, OH	Clients Na & Addres	me:		
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1. Form must be filled out completely for client to be reimbursed.

2. Only one signature, from one appointment is required.

3. Form to be used from 1st to last day of month and TURNED IN NO LATER THEN THE 5TH OF THE FOLLOWING MONTH.

- 4. Form may be faxed (faxing both sides), e-mailed, mailed (postdated no later than the 5th) or dropped in office mailbox (next to front door).
- 5. Miles computed from client's residence to treatment facility address using Google maps, using the shortest distance, and are rounded up to next whole number. Detours are not included.
- 6. Periodic calls will be made to treatment center(s) for verification.
- 7. We are unable to help with mileage if client is receiving help from another organization.
- 8. We do not do backpay. We only make payments when we have received your completed application form in our office.

Thank you, if you have questions concerning this form, please call us at the Phone number listed above. Our office hours are Monday-Thursday from 9am to 2pm.

Form is on back side of instructions.