NEW MEXICO REIMBURSEMENT LOG

Driver Name: ______________________ Relationship to Member: ______________________

Driver Mailing Address: ______________________ Driver Phone Number: ______________________

City/State/Zip Code: ______________________ Member ID: ______________________

Member Name (*if different from driver*): ______________________

Trip Date	Trip Number	Medical Provider Name & Phone Number	Provider Signature*	Total Miles
		Name: Phone Number:		
		Name: Phone Number:		
		Name: Phone Number:		
		Name: Phone Number:		
		Name: Phone Number:		

**NOTE: Each trip will be confirmed with the provider's office before payments will be made. Each date of service must have a provider signature to be approved. This form must be filled and submitted to Secure Transportation within 90 days of the service date for payment to be processed.*

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

Signature: ______________________

Fax to: (562) 236-4143

Send to: Secure Transportation
Attn: Mileage Reimbursement
12800 Center Court Drive S, Suite 120
Cerritos, CA 90703

Email to: MREncounters@securetransportation.com

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