



**APPOINTMENT VERIFICATION**

**Please complete and return by mail within 45 days of your appointment**

Member Name: \_\_\_\_\_ Payee: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ OHP #: \_\_\_\_\_

**SUBSCRIPTION TRIPS ONLY ENTER ONE LINE - YOUR TRIP CONFIRMATION WILL BE THE SAME FOR ALL THE SAME TRIPS, GOING TO THE SAME LOCATION - ATTACH A PRINTOUT OF THE DATES YOU ATTENDED!**

Date of Appointment	Time of Appointment	Reason for Appointment	Provider/Clinic Name AND Address	Provider/Clinic Phone	Provider/Clinic Signature & Stamp	Trip Confirmation Number (Call ReadyRide for number before your trip)
	_____AM  _____PM				▶ _____ Provider / Office Staff Signature                      Date  <div style="border: 1px solid gray; width: 100%; height: 40px; text-align: center; color: gray;">Provider Stamp Here</div>	Trip #: _____ One Way  Trip #: _____ Round Trip
	_____AM  _____PM				▶ _____ Provider / Office Staff Signature                      Date  <div style="border: 1px solid gray; width: 100%; height: 40px; text-align: center; color: gray;">Provider Stamp Here</div>	Trip #: _____ One Way  Trip #: _____ Round Trip
	_____AM  _____PM				▶ _____ Provider / Office Staff Signature                      Date  <div style="border: 1px solid gray; width: 100%; height: 40px; text-align: center; color: gray;">Provider Stamp Here</div>	Trip #: _____ One Way  Trip #: _____ Round Trip




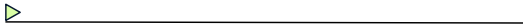

**All trips must be called in prior to your appointment. You will receive a trip confirmation number for each appointment. You must write that in on your form prior to sending it in. Please completely fill out the form to be eligible for reimbursement. Have each appointment entry signed and dated by your provider or office staff. You must return the form within 45 days of your appointment. Trips that are older than 45 days are not eligible for payment. Mail or drop off your completed form to: ReadyRide Services. 114 Assembly Circle, Grants Pass, OR 97526. For questions, or to schedule a trip, please call 800-479-7920 or 541-479-7920.**

**\*REMEMBER for lodging reimbursement with prior approval, please send in your original lodging receipt in members name with this form.**

**BY SIGNING THIS FORM, YOU ARE VERIFYING THE INFORMATION IS TRUE AND CORRECT.**

Member/Guardian Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Mailing Address (if different from home address) \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Appointment	Time of Appointment	Reason for Appointment	Provider/Clinic Name AND Address	Provider/Clinic Phone	Provider/Clinic Signature & Stamp	Trip Confirmation Number (Call ReadyRide for number before your trip)
	_____AM _____PM				 Provider / Office Staff Signature                      Date <div style="border: 1px solid gray; padding: 5px; width: fit-content; margin: 5px auto;">Provider Stamp Here</div>	Trip #: _____ One Way  Trip #: _____ Round Trip
	_____AM _____PM				 Provider / Office Staff Signature                      Date <div style="border: 1px solid gray; padding: 5px; width: fit-content; margin: 5px auto;">Provider Stamp Here</div>	Trip #: _____ One Way  Trip #: _____ Round Trip
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For Office Use Only:	Total Miles:
Total Lodging (prior authorized):	Total Meals (prior authorized):