SafeRide Claims Department

106 Jefferson St, Ste 300
San Antonio, TX 78205

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	Medical Provider Phone #	Physician/Clinician Signature*	Total Miles

*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 sunflower_claims@saferidehealth.com or fax to 1-888-453-5398.

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

Signature: ______________________________

KDHE-Approved 10/8/2024