TransLink Medicaid Medical Appointment Verification Form

<u>Please complete one (1) sheet for each of your appointments.</u> All your trip requests must be prior authorized (OAR 410-136-0300) through TransLink to qualify for reimbursement; Original verification sheets **(NO COPIES OR FAXES)** accepted 30 days from appointment. Separate sheets by cutting along the dotted line. **Send only completed sheets.**

			(Toll Free) 1.888.518.8160	
Medical Appointment Veri	fication Sheet		Complete ALL Sections -	One Per Appointment
Client Name:		OHP ID:	DOB (mm/dd/yyyy):	
Doctor/Clinic/Facility Name:			Physician Seen:	
Address:			Appt. Duration (h:mm):	:
Appt. Purpose:				
Appt. Date:	Appt. Time:			
Physician or Authorized Representatives Signa	ture Date	2	_	<u> </u>
Medical Appointment Veri	fication Sheet		Complete ALL Sections -	One Per Appointment
Client Name:		OHP ID:	DOB (mm/dd/yyyy):	
Doctor/Clinic/Facility Name:			Physician Seen:	
Address:			Appt. Duration (h:mm):	:
Appt. Purpose:				
Appt. Date:	Appt. Time:			
		_		
Physician or Authorized Representatives Signa	ture Date	3_		8_
				<u> </u>
			Complete ALL Sections -	
Medical Appointment Veri		OHP ID:		
Medical Appointment Veri			Complete ALL Sections -	
Medical Appointment Veri Client Name: Doctor/Clinic/Facility Name:			Complete ALL Sections - DOB (mm/dd/yyyy):	
Medical Appointment Veri Client Name: Doctor/Clinic/Facility Name: Address:			Complete ALL Sections - DOB (mm/dd/yyyy): Physician Seen:	
Medical Appointment Veri Client Name: Doctor/Clinic/Facility Name: Address: Appt. Purpose:			Complete ALL Sections - DOB (mm/dd/yyyy): Physician Seen:	
Medical Appointment Veri Client Name: Doctor/Clinic/Facility Name: Address: Appt. Purpose:	fication Sheet		Complete ALL Sections - DOB (mm/dd/yyyy): Physician Seen:	
Medical Appointment Veri Client Name: Doctor/Clinic/Facility Name: Address: Appt. Purpose: Appt. Date:	Appt. Time:		Complete ALL Sections - DOB (mm/dd/yyyy): Physician Seen:	
Medical Appointment Veri Client Name: Doctor/Clinic/Facility Name: Address: Appt. Purpose: Appt. Date: Physician or Authorized Representatives Signa	Appt. Time: Date	OHP ID:	Complete ALL Sections - DOB (mm/dd/yyyy): Physician Seen:	One Per Appointment
Medical Appointment Veri Client Name: Doctor/Clinic/Facility Name: Address: Appt. Purpose: Appt. Date: Physician or Authorized Representatives Signa Medical Appointment Veri	Appt. Time: Date Date	OHP ID:	Complete ALL Sections - DOB (mm/dd/yyyy): Physician Seen: Appt. Duration (h:mm):	One Per Appointment
Medical Appointment Veri Client Name: Doctor/Clinic/Facility Name: Address: Appt. Purpose: Appt. Date: Physician or Authorized Representatives Signa Medical Appointment Veri Client Name:	Appt. Time: Date Date	OHP ID:	Complete ALL Sections - DOB (mm/dd/yyyy): Physician Seen: Appt. Duration (h:mm): Complete ALL Sections -	One Per Appointment
Medical Appointment Veri Client Name: Doctor/Clinic/Facility Name: Address: Appt. Purpose: Appt. Date: Physician or Authorized Representatives Signa Medical Appointment Veri Client Name: Doctor/Clinic/Facility Name:	Appt. Time: Date dification Sheet	OHP ID:	Complete ALL Sections - DOB (mm/dd/yyyy): Physician Seen: Appt. Duration (h:mm): Complete ALL Sections - DOB (mm/dd/yyyy):	One Per Appointment
Medical Appointment Veri Client Name: Doctor/Clinic/Facility Name: Address: Appt. Purpose: Appt. Date: Physician or Authorized Representatives Signa Medical Appointment Veri	Appt. Time: Date dification Sheet	OHP ID:	Complete ALL Sections - DOB (mm/dd/yyyy): Physician Seen: Appt. Duration (h:mm): Complete ALL Sections - DOB (mm/dd/yyyy): Physician Seen:	One Per Appointment

Important Information Regarding Medical Appointment Verification Sheets:

- * Use **ONLY ONE** verification sheet for each of your medical appointments. Cut along the dotted lines to separate each sheet. Each verification form contains 4 separate verification sheets. Send only completed verification sheets to TransLink.
- * Verification sheets must be complete! Each verification sheet must be completed for you to receive all your requested reimbursement funds. Incomplete sheets may result in your reimbursement funds being reduced significantly. Please make sure your verification sheets are complete BEFORE you leave your medical appointment.
- * Lodging reimbursement requires a lodging receipt (The original receipt from either the hotel or motel where you stayed). Attach your lodging receipt to your completed verification sheet. Place all information into an envelope and send to the TransLink address listed on front of this page.
- * Meal requests **DO NOT** require receipts.
- * If you did not get prior authorization from TransLink for your transportation reimbursement request, your request for reimbursement will be denied. Please remember to schedule your reimbursement request as soon as you know about your appointment.