MILEAGE REIMBURSEMENT

Submit invoice to:
TripMaster
118 Circle Dr
Hampstead, NC 28443
Email: nmnemt@tripmasternemt.com Fax: 866-244-4351

Driver Info	Member Info
Name:	Name:
Street Address (mailing):	Member ID:
City/State/Zip:	Relationship to Driver:
Drivers License Number:	
Phone Number:	
Email:	

REQUIREMENTS FOR PAYMENT GAS MILEAGE REIMBURSMENT/BUS PASS:
Such services are funded in part with the State of New Mexico. Each trip will be confirmed with the provider prior to payment. Healthcare provider signature is required for each medical trip date. Submission to the TripMaster fax, email or mailing address shown on this form must occur within 90 days of the trip date, otherwise reimbursement may be declined.

Bus pass ☐ Gas mileage reimbursement ☐

TRIP DATE	TRIP NUMBER	HEALTHCARE PROVIDER NAME AND PHONE NUMBER	HEALTHCARE PROVIDER SIGNATURE	TOTAL MILES
		Name: Phone Number:		
		Name: Phone Number:		
		Name: Phone Number:		

I hereby certify that all of the information contained is true and correct. I have a current, valid, and open driver's license. The vehicle used to perform services has passed all state tests, has a current registration, and is insured according to the laws and regulations of the state to which the vehicle is registered.

X_____ _____

Driver Signature Date

I hereby certify that all of the information contained is true and correct.

X_____ _____ _____

Member Signature Member Name (Print) Date

If you have any questions concerning this invoice, call 877-236-0826