Interpreter Service's Mileage Request Form

Date of Request: ______________________

Interpreter Agency's Information

Provider's Name: ______________________
UCare Provider Number: ______________________
Provider's Phone: ______________________
Provider's Fax: ______________________
Contact Person's Name: ______________________
Contact Person's Phone: ______________________
Contact Person's Email Address: ______________________

Interpreter's Name: ______________________

Interpreteration Type: ☐ ASL ☐ Language ______________________

Member's Information

Date of Service: ______________________
Member's Name: ______________________
Member's ID #: ______________________

Appointement Type:
☐ Clinic ☐ Dialysis ☐ Other
☐ Hosptial Outpatient ☐ Pharmacy
☐ Ambulatory Surgery ☐ Home

Clinic/Facility's Name: ______________________

Address From: ______________________
____

Address To: ______________________
____

Total of Mileage Round Trip: ______________________

______________________ ______________________
Provider's Signature Date

UCare - Internal Office Use Only

Review By: ______________________ Date: ______________________
Approve Mileage Reimbursement: ☐ Yes ☐ No
Number of Mileage Approved: ______________________ Reimbursement: ______________________

Please fax the completed form to 612-884-2071.