**Mileage Reimbursement**

**CLAIM FORM**

**Month:……………….. Year: 2018**

**Scheme Registration Number:**

**Name of Claimant:**

**Dialysis unit:**

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| **Dates attended (own transport used).** No more than 3 months of journeys per claim | | | | | |
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| --- | --- |
| Number of dialysis sessions attended in claim period (own transport used) |  |
| No of return journeys claimed |  |
| No of single journeys claimed |  |
| Amount claimed: | ………..miles(at 30p per mile) **£** |

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| **Patient/Claimant Declaration**:  I declare that the information given on this form is true and complete to the best of my knowledge. I understand that action may be taken against me if I make an incorrect claim. I consent to the disclosure of relevant information on this form for the purposes of fraud prevention, detection and investigation.  **Patient’s Name:……………………………………………………………..**  **Signed: ……………………………………………………………………….. Date: …………………………** |

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| **Confirmation of dialysis attendance**:  I confirm that [ Patient ] attended dialysis sessions on the dates above:  **Staff name:………………………………………………………… Job Title:…………………….**  **Signed: ……………………………………………………………… Date: …………………………** |

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| **For Healthcare administrative staff use only**:  I confirm that I have checked the information provided above and authorise payment  **Authorising Manager:………………………………………………………**  **Signature of Authorising Manager: ……………………………………… Date: …………………………** |