NHS
Gloucestershire
Clinical Commissioning Group

Mileage Reimbursement
CLAIM FORM

Month:……………….. Year: 20…..

Scheme Registration Number: VSR

Name of Claimant:

Dialysis unit:

Journeys where own transport was used

Session Date	Single or return		Session Date	Single or return		Session Date	Single or return		Session Date	Single or return		Session Date	Single or return	
	S	R		S	R		S	R		S	R		S	R
	S	R		S	R		S	R		S	R		S	R
	S	R		S	R		S	R		S	R		S	R
	S	R		S	R		S	R		S	R		S	R
	S	R		S	R		S	R		S	R		S	R
	S	R		S	R		S	R		S	R		S	R
	S	R		S	R		S	R		S	R		S	R

Example:

Session Date	Single or return	
04/10/19	S	R ✓

Total single journey claims	
Total return journey claims	

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: ………………………….**

Confirmation of dialysis attendance:
I confirm that [Patient] attended dialysis sessions on the dates above:

Staff name:…………………………………………………………. **Job Title:……………………..**

Signed: ………………………………………………………………. **Date: ………………………….**

For Healthcare administrative staff use only:
I confirm that I have checked the information provided above and authorise payment

Authorising Manager:…………………………………………………………… **Value of Claim £………………..**

Signature of Authorising Manager: …………………………………….. **Date: ………………………………..**