Patient Medical Visit/Reimbursement Form

Medical Provider Completes

Proof of Physician/Treatment Center Visit

Patient Name _____ DOB _____ Service Date_____

The following medical service (s) were provided:

_____

Associated Product/Prescription: _____

Physician Name: _____

Practice/Treatment Center Name: _____

Address: _____

Phone: _____ Fax: _____

Name of person completing this form: _____

Position/Title of person completing this form: _____

I confirm the information provided above is correct:

_____ _____

Physician/Medical Office Representative Signature Date

PSI Patient Completes

If approved for PSI transportation assistance please provide the information below:

Mileage Reimbursement for a total of _____ round trip miles

Tolls/Parking (you must include receipts)

I verify this information is accurate and compliant with my approved PSI assistance:

_____ _____

Patient/Parent/Guardian Name (please print) Patient/Parent/Guardian Signature

Date _____ PSI ID # _____

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Patient Services Inc. *A National Non-Profit Organization*

P.O. Box 5930 • Midlothian, VA 23112 • Phone 1-800-366-7741 • Fax 1-804-744-9388 • www.patientservicesinc.org

Operating Hours: M, T, TH, F 8:30 AM -5:00 PM EST • W 9:30 AM - 5:00 PM EST