Ko-Kwel Wellness Center

630 Miluk Drive, PO Box 3190
Coos Bay, OR 97420
Phone (541) 888-9494 or (800) 344-8583
Fax (541) 888-0673

TRANSPORTATION REIMBURSEMENT FORM

*** FORM MUST BE COMPLETED TO RECEIVE REIMBURSEMENT ***

Requestor's Name: _____**Phone**:_____
(Please Print)

Eligibility: ***(Check all that apply)***

☐ Tribal member	☐ Veteran
☐ Tribal member spouse or widow/er (not remarried)	
☐ Elder (55+ years)	☐ Have a disability

Requestor is seeking:

☐ Reimbursement for public transportation, taxi, airfare, ride share service or the like. (*Please include a copy of your receipt.)*

☐ Mileage reimbursement for a driver transporting me. ***Driver must complete Driver Verification section below.***

Purpose of transportation: ☐ **Medical** ☐ **Non-medical** **Dates of travel:**_____

Starting Location (address): _____

Destination Address:_____

Med Facility Name *(If applicable)*:_____

☐ **One-Way trip** ☐ **Round trip**

(*A "trip" is 50 or more miles one-way--attach a separate sheet if more than one round trip and include starting location, destination and date of travel*)

Driver Verification *(for mileage reimbursement request only)*:

Driver's Name: _____ **Phone:** _____

Mailing Address: _____

_____

Driver Signature Date

Medical Appointment Verification *(If applicable):*

_____

Physician or Authorized Representative Signature Date

_____

Requestor Signature *Date*

Email this form to laurenmorris@coquilletribe.org