Greater Oregon Behavioral Health Inc.
3729 Klindt Drive
The Dalles, OR 97058
Phone: 1-877-875-4657
Email: mileage@gobhi.org

Proof of Healthcare Visit for Travel Payment Form

Usted puede recibir este documento en otro idioma, impreso en letra más grande o de cualquier otra manera que sea mejor para usted. Llame al número gratuito 1-877-875-4657. Los usuarios del servicio TTY pueden llamar al 711.

You can get this document in another language, large print, or another way that's best for you. Call 1-877-875-4657, TTY 711.

Instructions:

Client:

1. Please fill out the client information below.
    - The client is the person that has an appointment.
2. Give this form to your healthcare provider to complete and return to GOBHI.

Healthcare Provider:

1. Please fill out this form
2. Fax the completed form to: 1-855-541-1517.

Note:

- All requests must be called into GOBHI before the appointment date.
- To get reimbursed or paid:
    1. Turn in a signed Proof Form to GOBHI within 45 days of the appointment.
        - Forms turned in after 45 days will not be paid.
        - We will pay you back within 30 days if we receive your form on time.

For help:

- Call 1-877-875-4657 Toll Free or TTY 711
- Hours 7:00 a.m. to 5:00 p.m.
- Monday thru Friday

GOBHI Transportation 3729 Klindt Drive, The Dalles, OR 97058
Phone: 1-877-875-4657 or TTY 711 Fax: 1-855-541-1517

Client Name:	**OHP ID Number:**
Pay to (if not Client):	

☐ Mileage Reimbursement at $0.46 per mile

1st Request:

Appointment Date and Time:	
Name of Provider:	
Provider Address:	
Provider staff initials and signature:	
Time Appointment Ended:	

2nd Request:

Appointment Date and Time:	
Name of Provider:	
Provider Address:	
Provider staff initials and signature:	
Time Appointment Ended:	

3rd Request:

Appointment Date and Time:	
Name of Provider:	
Provider Address:	
Provider staff initials and signature:	
Time Appointment Ended:	

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☐ Lodging Reimbursement at $110.00 per night (with some exceptions)

Client Name:	**OHP ID Number:**

4th Request:

Appointment Date and Time:	
Name of Provider:	
Provider Address:	
Provider staff initials and signature:	
Time Appointment Ended:	
Original Receipt Included?	Check one box: ☐ Yes ☐ No If No, payment will not be made until the receipt is received.

5th Request:

Appointment Date and Time:	
Name of Provider:	
Provider Address:	
Provider staff initials and signature:	
Time Appointment Ended:	
Original Receipt Included?	Check one box: ☐ Yes ☐ No If No, payment will not be made until the receipt is received.

☐ Meal Reimbursement:

- You qualify for meals if:
  - Travel begins before 6:30am,
  - Travel happens between 11:30am to 1:30pm, or
  - Travel ends after 6:30pm.
- **Receipts not required.**
- $34 per day
  - Breakfast at $9.00
  - Lunch at $10.00
  - Dinner at $15.00