



Mileage Reimbursement Form for Cancer Treatments or Miscellaneous Visits

Patient's Name: _____

Address: _____ Phone: _____

Name of Treatment Center _____

Address: _____ Phone: _____

Physicians Signature _____

Please complete the dates and have this signed below. The purpose of this form is to apply for reimbursement for any mileage accumulated during trips for cancer related needs, such as radiation and/or chemotherapy treatment, MD appointments, labs, tests, etc. Patient does not need to track mileage, MapQuest will be used from patient's address to treatment center, please provide full address for both and use a different form for each doctor or treatment center. Please submit at least quarterly for payment.

Date	Treatment Center Signature (Can be signed by nurse)	Date	Treatment Center Signature (Can be signed by nurse)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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Please return form to:
 The Putnam County Cancer Assistance Program
 PO Box 165
 Glandorf, OH 45848
 419-235-6487 / 419-538-6482
 Fax: 419-943-1040
<http://www.pccap.org>

