Individual Transportation Participant (ITP) Trip Submission Form

Texas Children's Health Plan | veyo

This form can be used to request reimbursement for driving a TCHP Member to a healthcare appointment. This form can be used for up to 5 medical appointments of mileage reimbursement from the Member's home address to a single medical facility location. Veyo must receive the completed form via mail, email or fax within 30 days of the first medical appointment listed on the form. Mileage will be reimbursed at the current IRS mileage rates. Google Maps will be used to determine the distance between the from and to location. Payment will be sent to the member or documented driver within 45 days from receipt of reimbursement request.

MEMBER INFORMATION

First Name:	Last Name:	
Medicaid ID:	Date of Birth (MM/DD/YYYY):	
Phone Number:	Home Address:	City:
State:	Zip Code:	Driver's Relationship to Member:

DRIVER INFORMATION

First Name:	Last Name:	Phone Number:
Email Address:	Mailing Address:	
City:	State:	Zip Code:
Driver's License Number:	Issuing State:	Expiration Date:

TRIP INFORMATION

Appointment Date (MM/DD/YYYY):	Appointment Time: ____ ☐ AM ☐ PM	Start Address: ☐ Home	Provider Address: ☐ RT ☐ One Way
Healthcare Provider/Facility Name:	Phone Number:	Licensed Healthcare Provider Signature:	Print Healthcare Provider Name:
Appointment Date (MM/DD/YYYY):	Appointment Time: ____ ☐ AM ☐ PM	Start Address: ☐ Home	Provider Address: ☐ RT ☐ One Way
Healthcare Provider/Facility Name:	Phone Number:	Licensed Healthcare Provider Signature:	Print Healthcare Provider Name:
Appointment Date (MM/DD/YYYY):	Appointment Time: ____ ☐ AM ☐ PM	Start Address: ☐ Home	Provider Address: ☐ RT ☐ One Way
Healthcare Provider/Facility Name:	Phone Number:	Licensed Healthcare Provider Signature:	Print Healthcare Provider Name:
Appointment Date (MM/DD/YYYY):	Appointment Time: ____ ☐ AM ☐ PM	Start Address: ☐ Home	Provider Address: ☐ RT ☐ One Way
Healthcare Provider/Facility Name:	Phone Number:	Licensed Healthcare Provider Signature:	Print Healthcare Provider Name:
Appointment Date (MM/DD/YYYY):	Appointment Time: ____ ☐ AM ☐ PM	Start Address: ☐ Home	Provider Address: ☐ RT ☐ One Way
Healthcare Provider/Facility Name:	Phone Number:	Licensed Healthcare Provider Signature:	Print Healthcare Provider Name:

Driver Attestation:
Yes or No _______ I adhere to all public laws, ordinances, and regulations applicable to drivers and the vehicles that I use
Yes or No _______ At time of transport, my drivers license was not restricted or suspended.
I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both. I declare under penalty of perjury under the laws of the United States of America and the State of Texas that the foregoing Trip Information listed above is true and correct. I hereby certify that the foregoing Trip Information is in compliance with Veyo's policies and procedures.

______________________________ ____________
Driver Signature Date

____
Print Driver Name

______________________________ ____________
Member Signature Date

____
Print Member Name

Please submit completed forms by email, mail, or fax:

Email: mrb@veyo.com

Fax: 1-855-667-2557

Mail: Veyo
Attn: Mileage Reimbursement
10010 N 25th Ave, Ste 400,
Phoenix, AZ 85021

Last updated: May 20, 2021