Interpreter Services Mileage Request Form

Fax form to: 612-884-2232
Form Updated: Dec. 21, 2020

Date of Request: _____

Interpreter Agency Information

Interpreter Agency Name: _____
UCare Provider Number: _____
Provider Phone: _____
Provider Fax: _____
Contact Person's Name: _____
Contact Person's Phone: _____
Contact Person's Email Address: _____

Interpreter Name: _____

Interpreter's MDH Roster ID Number: _____

Interpretation Type: ☐ ASL ☐ Language _____

UCare Member Information

Date of Service: _____
Member Name: _____
Member ID #: _____

Appointment Type:
☐ Clinic ☐ Dialysis
☐ Hospital Outpatient ☐ Pharmacy
☐ Ambulatory Surgery ☐ Home

Facility Name: _____

Address From: _____

_____

Address To: _____

_____

Total Mileage Round Trip: _____

_____ _____
Interpreter Agency Staff Signature Date

UCare - Internal Office Use Only

Review By: _____ Review Date: _____
Approve Mileage Reimbursement ☐ Yes ☐ No
Number of Miles Approved: _____ Reimbursement: _____

Please fax the completed form to 612-884-2444.