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Kidney Foundation
of Northwest Ohio

MILEAGE REIMBURSEMENT

MONTH: ____________________ YEAR _______

RETURN THIS FORM TO KFNWO BY THE 5th OF THE MONTH FOLLOWING THE MONTH TRAVEL OCCURRED

Kidney Foundation of Northwest Ohio
3100 W. Central Ave., Ste. 250
Toledo, OH 43606
(419) 329-2196-phone (419) 531-6080-fax www.kfnwo.org

NAME: ____

ADDRESS: _____________________________________

CITY: ________________STATE: _____ ZIP: _________

PHONE: ( ) __________________________________

☐ Please check this box if this is a new address

DIALYSIS CENTER: _______________________________________
TRANSPLANT CENTER: ____________________________________

 # OF TRIPS TO DIALYSIS: _____ # OF MILES ONE WAY: ________

OTHER MEDICAL TRIPS

NAME OF PROVIDER: ________________ADDRESS:_________________
OF TRIPS: _________ # OF MILES ONE WAY: ___________________

NAME OF PROVIDER: ________________ADDRESS:_________________
OF TRIPS: __________# OF MILES ONE WAY: ___________________

Signature: ____________________________ Date: _________________
Social Worker's Signature: ______________________________________
(Note: Social worker, by signing this form, you are verifying the patient's attendance)

Kidney Foundation of Northwest Ohio reserves the right to refuse payment on any reimbursement request past 30 days

For Office Use Only-Do Not Write Below
Month ________Total Miles _____@ .18 per mile= _____ Amount Reimbursed $ _______

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For Office Use Only-Do Not Write Below

Month _________Total Miles _____@ .18 per mile= ______ Amount Reimbursed $ ________