

**Oklahoma Health Care Authority  
Self-Directed Services  
Mileage Reimbursement Request Form**

**Employee Name:** \_\_\_\_\_ **Member Name:** \_\_\_\_\_

Date	Destination	Total Miles: To and From Destination	Total Amount (.47 per mile)

**\*Mileage Reimbursement can not be claimed for the following:**

- 1. To and from Day Services
- 2. To and from supportive and competitive employment
- 3. Transporting school aged children to and from school

**\*\*Employee must have current automobile insurance. Vehicles used to transport members must have seat belts and must be used by the member at all times. Each vehicle must have first aid supplies.**

**\*\*Inaccurate or incomplete documentation will be returned for correction, which may result in delay of payments.**

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Employer/Member Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**For OHCA Approval mail or fax to:**  
Attn: Long Term Care Administration  
Oklahoma Health Care Authority  
4345 N. Lincoln Blvd.  
Oklahoma City, OK 73105  
**Phone:** 888-287-2443  
**Fax:** 405-530-7265