Wyoming Department of Health

Wyoming Medicaid DME Mileage Verification Form

Provider Name _____

Provider Number _____

Client Name _____

Client ID # _____

Date of Service _____

Travel Information

Begin City _____ **Destination City** _____

Total Miles _____ **X 2 (round trip) =** _____
(Total Distance from Begin City to Destination City; obtained from http://www.mapquest.com) (Mileage)

Mileage _____ **- *50 miles =** _____
(* The first 50 miles are not reimbursable) (Reimbursable Miles)

Reimbursable Amount = _____ **X $0.40/Mile = $** _____
(Reimbursable Miles)