**Mileage Reimbursement Request**

**Client’s Name**

**Address**  **Telephone #**

**Email address**

**Parent/Guardian**

**Name and location of healthcare facility** where appointment was kept or treatment given:

**Healthcare facility name**

**Healthcare facility address**

**Date of visit:**

**Physician providing care for visit**

Printed name Signature

It is the desire of the Ella Mae Bransom Sickle Cell Association (EMBSCA) to assist Colorado Springs Sickle Cell patients by defraying travel expense for appointment visits to a healthcare provider\facility.

**For visits in Colorado Springs**

$5 Minimum per visit

**For visits in to Denver**

$30 Maximum allowable per visit

$100 Total monthly maximum allowable reimbursement for all locations in any combination.

This is a courtesy extended to patients\families by the EMBSCA and will not be considered binding to the organization in any way. The EMBSCA reserves the right to reimburse in part, full, or not at all.

Please provide a copy of scheduled appointments with this completed form. **Submit forms the month of the appointment.**

Mail completed form to:

Ella Mae Bransom Sickle Cell Association

P.O. Box 16456

Colorado Springs, CO 80935