



WEST VIRGINIA  
Breast & Cervical  
CANCER SCREENING PROGRAM  
You're Worth It

### Patient Transportation Reimbursement Form

#### **Section 1: Identifying Information**

Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

The client listed has indicated the need for assistance in securing funds for transportation to a medical facility.

#### **Section 2: Verification of Attendance**

In order for the WVBCCSP to provide these transportation funds, it is necessary to certify the patient's attendance at your facility through the completion of this form.

Name of Facility: \_\_\_\_\_  
Date Patient Attended: \_\_\_\_\_  
Signature of Facility Representative: \_\_\_\_\_

#### **Section 3: Driver Responsibility**

Driver/Provider's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Mileage and Travel: Odometer reading \_\_\_\_\_ to \_\_\_\_\_  
(beginning) (ending) (total mileage)

I certify that the information provided above is true and correct to the best of my knowledge and as a transportation provider, I agree to carry the minimum liability insurance \* required on a vehicle by the state of WV.

\*\$20,000 for injury or death to one person in an accident or \$24,000 for injury or death to two persons in one accident and \$10,000 property damage.

Signature of Driver: \_\_\_\_\_

#### **Section 4: Patient Responsibility**

Please request the facility representative complete Section 2 above. Please return this form as soon as possible. Failure to return this form may result in a denial of future requests for transportation funds.

Signature of Patient: \_\_\_\_\_

Return this form to: Clay County Health Department  
WVBCCSP  
PO Box 36  
452 Main Street  
Clay, WV 25043