Cancer Association of Anderson

215 E. Calhoun Street

Anderson, SC 29621

GAS REIMBURSEMENT FORM

PATIENT NAME _____

ADDRESS: _____ _____ **SC ZIP** _____

Date of Trip	**Medical Facility**	**Purpose of Visit (Phy. or Treatment)**	**Mileage – Round Trip**	**Facility Staff Initial**	**Patient Drove (√)**	**Another Drove (√)**

INSTRUCTIONS FOR PATIENT: Use this form to keep a record of your trips to medical appointments for cancer treatment and oncology rehabilitation. List the date, the appointment and the round-trip mileage and have someone on the office staff initial it. **You may turn in this form once a month for reimbursement of 20 cents per mile up to $100 a month.**

INSTRUCTIONS FOR MEDICAL STAFF: Please initial this chart in the last column to confirm the patient was at your office on the date indicated. If you have questions, call the Cancer Association of Anderson at 222-3500. Thank you!

PATIENT SIGNATURE _____ **DATE** _____

DATE RETURNED TO CAA _____ **STAFF** _____

CAA is not affiliated with or supported by the American Cancer Society Revised: November 12, 2008