

**NCEA - SENIOR MEDICAL TRAVEL REIMBURSEMENT REQUEST**  
(Must be age 60+ and Year-Round resident to be eligible for Reimbursement)

Date: \_\_\_\_\_

**CONTACT INFORMATION**

Patient Name: \_\_\_\_\_

Resident Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Patient date of birth \_\_\_\_\_

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**TRANSPORTATION INFORMATION**

Date of Medical Care: \_\_\_\_\_

Type of Transportation/Lodging: \_\_\_\_\_

Provider/location of Service \_\_\_\_\_

Total Amount: \_\_\_\_\_

Amount requested for reimbursement: \_\_\_\_\_

Note: Maximum of \$500.00 per application for reimbursement/maximum of \$1,750.00/year

**\*\*\*\*\* Receipt and/or Proof of Payment must be submitted with this form. Please attach.**

Please submit this form for approval and all receipts attached to:

NCEA SENIOR MEDICAL TRAVEL

Saltmarsh Senior Center, 81 Washington Street, Nantucket, MA 02554

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

Approved payments will be mailed to the address listed above in approximately two weeks.