Metro-Card
Transportation Reimbursement Log

PURPOSE: Member Metro-Card Reimbursement

Contact # _____

Primary Care Site:_____

Address: _____

Address: _____

Dept: _____

Manager: _____

Date	Member CIN	Member Name	Type of Service	# of MetroCards Dispensed	Total
				0	$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
					$ -
				0	
					$ -

APPROVED: _____

_____

Reimbursement Amount $ -

Please complete all information above and log sheet must be signed by Director or Manager of Department. You may fax your log to (646) 786-1837 or mail it in to Amida Care, 248 West 35th Street, 7th Floor, New York, NY 10001, attention Finance. Thanks.