One Gloucestershire
Transforming Care, Transforming Communities

NHS Gloucestershire

Dialysis Mileage Reimbursement Registration Form

NAME OF CLAIMANT *(and relationship to patient)*	
NAME OF PATIENT *(if different from above)*	
ADDRESS	
POSTCODE:	
EMAIL ADDRESS *(for payment remittance only)*	
TELEPHONE NUMBER *(in case of any queries)*	

DIALYSIS UNIT: Cotswold ☐ **Severn** ☐ **Forest** ☐ **Other** ☐ *(please specify)*

If you do not attend the closest unit to your home we may ask you to provide confirmation from your clinician that it is clinically necessary for you to travel to a more distant unit. Without clinical confirmation we may only be able to pay the equivalent mileage to the closest unit.

I confirm that:	**TICK**
I [*the patient*] am registered with a Gloucestershire GP	☐
I will notify NHS Gloucestershire Integrated Care Board (ICB) of any changes to: • **Location and/or frequency of dialysis treatment** • **Home address** • **GP registration** • **Any other significant changes which impact transport to dialysis**	☐

I CONSENT TO THE INFORMATION I HAVE SUPPLIED TO BE USED FOR PROCESSING MY CLAIMS.
This information will be processed in line with General Data Protection Regulations (GDPR)

SIGNATURE [*of Patient*]: **DATE:**

Following registration you will receive a confirmation letter and registration number

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PAYMENT WILL BE MADE BY DIRECT BANK TRANSFER

CLAIMANT'S BANK DETAILS	
ACCOUNT HOLDER NAME:	
ACCOUNT NUMBER:	
SORT CODE:	

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