MEDICAL TRANSPORTATION CLAIM

Branch 24

Please ***(1)*** *fill out* ***ALL*** *required information,* ***(2)*** *use one form for each month* ***(3) RETURN completed form to caseworker within 45 days***

Foster Parent: **Provider#** **Month:**

Address: **Phone:** **Caseworker:**

Child(ren) Tranported

1 *Case Number* *Person Letter*

2 *Case Number* *Person Letter*

3 *Case Number* *Person Letter*

4 *Case Number* *Person Letter*

Foster parent has requested reimbursement for medical transportation provided to child(ren) listed above. Child(ren) had no other resource available.

Date(s)	Child(ren) Transported (#)	Destination Name, Address & Reason **(Please be Specific) Ex.: Home/Options 1255 Pearl/Counseling or Home/Dr.Miller 2000 Pearl/dental	Total Round Trip Miles	Total Miles x .25	TOTAL
				x .25	
				x .25	
				x .25	
				x .25	
				x .25	
				x .25	
				x .25	
				x .25	
				x .25	
				x .25	
				x .25	

Foster Parent Signature:_____ **Date:**_____

Caseworker Signature:_____ **Date:**_____

Supervisor Signature:_____ **Date:**_____