PROVIDER TRANSPORTATION RECORD

MONTH/YEAR _____

The first three columns must be completed by the county DSS. The transportation provider must complete the last three columns.

Recipient Name	Medicaid ID #	Eligibility Period	Dates Transported	Destination	Cost
1.					
2.					
3.					
4.					
5.					

I hereby certify that transportation was provided on the dates above for each recipient for whom cost is being claimed.

_____

Transportation Provider Signature

_____

Date