NON-MEDICAL TRANSPORTATION –PER MILE

Provider: _____ Contract #: _____ Vehicle License #: _____ Month: _____ Year: _____

Date	Driver's Initials	Start Odometer	Pick up time	Drop-off Time	End Odometer	Total Miles	Modified Vehicle Rate (Y/N)*	Passengers	Medicaid #	Other Paid Staff or Riders

Driver's Signature: _____ Initials_____ Driver's Signature: _____ Initials_____

Driver's Signature: _____ Initials_____ Driver's Signature: _____ Initials_____

****Attach Non-Medical Transportation Daily Checklist if required for your vehicle****

*The Modified Vehicle Rate is only applicable when at least one passenger requires a modified vehicle as specified in his or her individual service plan. The rate then applies to all passengers while that passenger is present.

NMT Rule OAC 5123-9-18

Rev. 01/2022

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Date	Notes	Initials