

Per Mile Non-Medical Transportation – SERVICE DELIVERY DOCUMENTATION FORM –

County _____

PROVIDER NAME: _____

PROVIDER #: _____

Date	Vehicle License Plate Number	Start time of commute	End time of commute	Beginning Odometer Reading	Ending Odometer Reading	Total number of miles	All passengers, staff, and/or volunteers in the vehicle during any portion of the commute <i>Used in conjunction with Key below</i>									Driver Initials
							1	2	3	4	5	6	7	8	9	

Per Mile Non-Medical Transportation – SERVICE DELIVERY DOCUMENTATION FORM –

County _____

PROVIDER NAME: _____

PROVIDER #: _____

Key	Individual/Staff/Volunteer Name	Individual Medicaid Number (if applicable)
1		
2		
3		
4		
5		
6		
7		
8		
9		

If vehicle is modified or equipped to transport five or more passengers, annual and daily inspections are required and maintained on additional documentation sheets.

Printed Name: _____ Signature: _____ INITIALS: _____ DATE: _____

Printed Name: _____ Signature: _____ INITIALS: _____ DATE: _____

Printed Name: _____ Signature: _____ INITIALS: _____ DATE: _____

Printed Name: _____ Signature: _____ INITIALS: _____ DATE: _____

Printed Name: _____ Signature: _____ INITIALS: _____ DATE: _____