NON-MEDICAL TRANSPORTATION –PER TRIP

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

Date	Driver's Initials	Pick up time	Drop-off Time	Billing Units	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 Inspection Checklist if required for your vehicle****

Date	Notes	Initials