

CSHS Health KiCC

For Office Use Only

Mileage

Amt Pd

Authorization OK

MEDICAL TRANSPORTATION REIMBURSEMENT FORM

-To Be Returned After Your Trip-

CSHS Health KiCC Client _____ Date of Birth _____

Address _____

Phone # _____

Payment Goes To _____

Address _____

Phone # _____

Social Security Number _____

W-9 must be completed or on file for person receiving travel reimbursement.

Appointment Date _____ Appointment Time _____

City of Origin _____ Destination (City) _____

If using public transportation, the original receipt **MUST** accompany this form.

To be filled out by medical provider

Name of Medical Provider _____

Address & Phone Number _____

Type of Provider _____

Purpose of Visit _____

_____ Date _____

(Medical Provider/Representative)

- Mileage will be reimbursed according to established program guidelines.
- Travel must be at least 10 miles outside of your city limits in order to be eligible for reimbursement.
- Reimbursement must be submitted within one (1) year.

I declare and affirm under the penalties of perjury that this claim has been examined by me,
and to the best of my knowledge is in all things true and correct.

SIGNATURE _____ DATE _____

(recipient, parent, or guardian)

If you have questions about completing this form, please call (800) 305-3064 or email dohchshshealthkicc@state.sd.us.

Please return to:
CSHS Health KiCC
600 E. Capitol Avenue
Pierre, SD 57501

NOTE

There are penalties for fraudulently submitting claims for reimbursement