MAINE DEPARTMENT OF HEALTH & HUMAN SERVICES **Reimbursement for Transportation Services Mileage Reimbursement**	
PAY TO: **Full Name:**	
Remit to Mailing Address:	
Vendor #:	**Today's Date:**
Transportation for Client/Person:	
Client A#:	**Case ID:**
Case Name, if different:	
Caseworkers Name:	

Date of Travel & Name of the Child	**Enter Town to Town to Town**	**Service Codes: *See Below**	**R92 Travel Reason:**	**Actual Miles**	**Amount @ $.56 per Mile**	**Other Expenses; Attach receipt**

				TOTALS:		
					GRAND TOTAL:	

*Service Codes for Transportation: **M92** for visit to MaineCare provider or service; **N92** Visit with the child's parent; or **R92** All Other (must indicate in "R92 Travel Reason")

I am not requesting reimbursement for this transportation from any other public or private entity or organization.

Submitter's Signature
Caseworker's Signature
Supervisor's Signature

NOTE: Travel must be submitted within 90 days of the earliest travel requested on the form. Requests submitted beyond 90 days will not be processed or paid.