FILLMORE COUNTY COMMUNITY SERVICES

902 Houston Street NW, Suite #1
Preston, MN 55965
Telephone: 507-765-2175; Fax: 507-765-3895

CLAIM FOR REIMBURSEMENT OF MEDICAL TRAVEL

- **Transportation for necessary medical care at the closest provider providing the level of care needed**
- **Claim form needs to be received within 60 days of your appointment, unless retroactive MA**
- **Most direct route will be determined by Mapquest**
- **Please attach original receipts for meals and parking (exception: Metered parking)**

Name of Driver:	Name of Client:
Driver Address:	Client Address:
	Client Date of Birth:
	Case Number:

TO BE COMPLETED BY MEDICAL PROVIDER

Starting Address (pick up address)	Medical Provider Name & Address (Destination)	Mileage Round Trip	Meal	Parking	*Signature of Medical Provider*	Date Seen

I declare under the penalties of law that this claim or demand is just and correct and that no part of it has been paid.

_____ _____

Signature of Client or Parent if minor (patient seen) **Signature of Driver (person receiving check)**

Eligibility verified by:_____ Date:_____

For Accounting Department Use Only:

Total Miles: _____Rate: _____

Total Payment: _____