REIMBURSEMENT FOR TRAVEL TO/FROM APPROVED PROVIDER(S) FOR 50 MILES OR MORE ROUNDTRIP

State Form 50254 (R/12-03)
Form approved by State Board of Accounts, 2003

INSTRUCTIONS

1. All sections completed, printed, and legible.
2. Signatures must be original in ink.
3. Maximum of three (3) travel dates per form.
4. One year filing limit from date of travel.
5. Return to CSHCS.

INDIANA STATE DEPARTMENT OF HEALTH
CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS)
2 NORTH MERIDIAN STREET
INDIANAPOLIS, INDIANA 46204

PARTICIPANT INFORMATION		COMPLETED BY PARENT/GUARDIAN
Name of Child	Date of Birth (month, day, year)	CSHCS #
Street address of participant (number and street, city, state, ZIP code (spell city name completely)		

TRANSPORTATION INFORMATION	COMPLETED BY PARENT/GUARDIAN/DRIVER
Date(s) of Travel (month, day, year & maximum of three per claim)	
To (number and street, city, state, ZIP code (spell city name completely)	
Reason(s) for Visit(s)	
Name of Driver	Driver's License # (provide copy if not Indiana)
Driver's Date of Birth	Vehicle Plate # (provide copy of registration if not Indiana)

MEDICAL PROVIDER INFORMATION	COMPLETED BY MEDICAL PROVIDER
Name of Medical Provider (printed)	
Signature of Medical Provider (must be in ink)	Date (month, day, year)

PARENT/GUARDIAN INFORMATION	COMPLETED BY PARENT/GUARDIAN
Mailing address of parent/guardian, if different from above (number and street, city, state, ZIP code (spell city name completely)	
Name of Parent/Guardian (printed)	
Signature of Parent/Guardian (must be in ink)	Date (month, day, year)

I hereby certify that the foregoing account is just and correct, that the amount claimed is legally due, after allowing all just credits, and that no part of the same has been paid.