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

State Form 50254 (7-01)
Approved by State Board of Accounts, 2001

INDIANA STATE DEPARTMENT OF HEALTH
CHILDREN'S SPECIAL HEALTH CARE SERVICES

INSTRUCTION

1. *Mileage will be reimbursed at the rate of $.28 per mile for the first 500 miles; $.14 per mile for the next 2,000 miles.*
2. *Mileage will not be approved for trips in excess of 2,500 miles round trip.*
3. *All mileage will be calculated on the Indiana State Mileage Chart.*

PLEASE FILL OUT IN BLACK OR BLUE INK.
PLEASE PRINT

PATIENT INFORMATION		
Name of child	Date of birth (*month, day, year*)	Case number
Address (*number and street, city, state, ZIP code*) (*CITY MUST BE SPELLED OUT COMPLETELY.*)		

TRANSPORTATION DETAILS
Date of travel: (*month, day, year*) (*must be in ink*)
To: (*number and street, city, state, ZIP code*) (*CITY MUST BE SPELLED OUT COMPLETELY.*)

MEDICAL PROVIDER		
Name of Medical Provider (*printed only*)		
Signature of Medical Provider (*must be in ink*)		Date (*month, day, year*)
Reason for visit:		

PARENT / GUARDIAN INFORMATION
Name of Parent / Guardian (*printed only*)
Signature of Parent / Guardian (*must be in ink*)
Mailing address (*number and street, city, state, ZIP code*) (*CITY MUST BE SPELLED OUT COMPLETELY*)

ALL FIELDS ABOVE MUST BE COMPLETED LEGIBLY

FOR STATE USE ONLY	
Signature of authorized CSHCS staff	
Total mileage:	Total reimbursement: