

CPS- Provider Mileage Form

A. Provider

NAME	RESOURCE #
ADDRESS (street/PO box, city, state, zip)	MONTH/YEAR

B. Client

NAME	CLIENT ID #
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C. Medical (approved by CPS, after denial from Medicaid NEMT Program)- Service Code 09-007

Date	# of Miles (units)	Short Description	Unit Price	Amount	Client ID# of others transported
			\$.70/ mile		
			\$.70/ mile		
			\$.70/ mile		
			\$.70/ mile		
			\$.70/ mile		
			TOTAL*		

D. Non-medical (approved ahead of time by CPS)- Service Code 09-008

Date	# of Miles (units)	Short Description	Unit Price	Amount	Client ID# of others transported
			\$.70/mile		
			\$.70/mile		
			\$.70/mile		
			\$.70/mile		
			\$.70/mile		
			\$.70/mile		
			\$.70/mile		
			TOTAL*		

*Total Amounts from C & D must be placed on CPS-522 Request for Payment (1 Line for each code)

IMPORTANT: Transportation cost reimbursements must receive prior approval from the CPS caseworker and supervisor. Please consult the SD Foster Parent Handbook for examples of eligible transportation costs.

Provider Signature _____ Date _____