STATEMENT OF TRAVEL EXPENSE

Medicaid Claimant (Please Print) _____Month of _____ Year_____ Medicaid #_____

Date	Between What Points		Miles @ _____¢	Amount	Trip Purpose & Address	Other Expenses
	From Home	To Med. Apt				
Mileage Total:					**Other Expenses Total:**	

I hereby certify that the distances for which charges are made in this statement have been necessarily traveled and that expenses for which reimbursement is claimed were incurred in the service of the County.

Signature of Claimant _____ ***Please make Checks payable to:*** _____