Reset Form

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

State Form 50254 (R2 / 12-23)
Form approved by State Board of Accounts, 2003

**INDIANA DEPARTMENT OF HEALTH**
**CHILDRENS SPECIAL HEALTH CARE SERVICES (CSHCS)**
2 North Meridian Street
Indianapolis, IN 46204

**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.*

| **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. | |