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|  | **MISSOURI DEPARTMENT OF SOCIAL SERVICES**  **FAMILY SUPPORT DIVISION**  **MO HealthNet Spend Down Transportation Expense Log** | | | | | | | | | | | | | | |
| **Participant Instructions:** If you wish to claim transportation costs toward your spend down, please complete and return this form to a Family Support Division office. You will need to attach a receipt or bill for the service you received, such as receipt for the prescription you picked up or the doctor appointment you kept.\* | | | | | | | | | | | | | | | |
| **Participant Name (Please Print):** | | |  | | | | | | **MO HealthNet Number:** | | |  | | |  |
|  | | | | | | | | | | | | | | | |
| **Date of Service** | | **Medical provider name, address and type of service \*** | | | **Round trip distance** | | **Who provided the transportation? Phone number** | | | **Signature of person providing transportation** | | | | **Total Amount of Charge\*\*** | |
| **EX. 11/30/12** | | **Dr. Smith, 201 Main St, Anytown MO – oncology** | | | **20 miles** | | **John Doe**  **573-222-3333** | | | **John Doe** | | | | **$10.00** | |
|  | |  | | |  | |  | | |  | | | |  | |
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| \* Attachments verifying the information above must match the dates of services listed.  \*\* The amount you paid will not be allowed if it exceeds the state mileage rate. If this occurs, the state rate will be applied. | | | | | | | | | | | | | | | |
| **PLEASE COMPLETE AND SIGN ATTESTING TO THE ACCURACY OF INFORMATION PROVIDED:** | | | | | | | | | | | | | | | |
| Name of Person Completing Form (Please print): | | | | | |  | | | | | Phone: | |  | |  |
| Address: |  | | | | | | | | | | | | | |  |
| Signature of person completing form (required): | | | |  | | | | | | | | | | |  |
|  | | | | | | | |  | | | | | | | |
| MO 886- (6-13) | | | | | | | |  | | | | | | | |