Wyoming Department of Health

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Thomas O. Forslund, Director **Governor Matthew H. Mead**

SECTION I

TRANSPORTATION EXPENSE VERIFICATION FORM

Prior Authorization Number_____

(Required for reimbursement to be processed)

Please Print

This verifies that I, _____, provided transportation for
(NAME OF PERSON RECEIVING REIMBURSEMENT)

_____, on _____ to an appointment at
(NAME OF CLIENT) (DATE)

_____
(NAME OF AGENCY/PROVIDER, CITY AND STATE)

By signing this form, I affirm that the above information is an accurate statement of assistance. I affirm that I am not a client of the Communicable Disease Treatment Program. I further understand that if I deliberately provide false information, the Applicant may be removed from the Program, prosecuted under applicable state and federal statutes, or both.

_____ _____
SIGNATURE OF PERSON PROVIDING TRANSPORTATION DATE

_____
ADDRESS WHERE REIMBURSEMENT IS TO BE MAILED: (STREET, CITY, ZIP)

SECTION II

Please Print

This verifies that _____ came to our office
(name of applicant)
on _____ for an appointment. The purpose of this appointment was
(date)

_____

_____

Agency/Provider: _____ Date: _____

Address: _____

Signature: _____Phone: _____

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