

TAXI TRANSPORTATION VOUCHER

DEPARTMENT OF HEALTH AND HUMAN SERVICES MEDICAL SERVICES

SFN 170 (3-2023)

SFN 170 (3-2023)				
Recipient Name:		Medicaid ID N	Medicaid ID Number:	
Recipient Address:	City:	State:	Zip Code:	
Telephone Number:				
Destination:				
То:				
Destination:				
From:				
Pick Up Time:	Date of Appointment:	Round Trip Yes N	lo	
UNAUTHORIZED REPRODUCT Human Service Zone Office:		SE OF THIS FORM WILL CONSTITUTE FRAUD Human Service Zone Staff Signature:		
Recipient Signature:	1	Taxi Trip Ticke	t Number:	
	PORTATION VOUCHER F HEALTH AND HUMAN SERVICES CES	Medicaid ID N	lumb or	
Recipient Name:		Medicaid ID N	lumber:	
Recipient Address:	City:	State:	Zip Code:	
Telephone Number:		1		
Destination:				
To:				
Destination:				
From:		<u>, </u>		
Pick Up Time:	Date of Appointment:	Round Trip Yes	Round Trip Yes No	
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UNAUTHORIZED REPRODUCTION OR USE OF THIS FORM WILL CONSTITUTE FRAUD

Human Service Zone Office:	Human Service Zone Staff Signature:	
Recipient Signature:		Taxi Trip Ticket Number: