TAXI TRANSPORTATION VOUCHER

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
SFN 170 (01-2006)

Clear Fields

Recipient Name:		Medicaid ID Number:	
Recipient Address:	City:	State:	Zip Code:
Destination: To:		From:	
Date of Appointment:			

UNAUTHORIZED REPRODUCTION OR USE OF THIS FORM WILL CONSTITUTE FRAUD

County:	County Staff Signature:
Recipient Signature:	Taxi Trip Ticket Number:

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