TAXI TRANSPORTATION VOUCHER

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES
SFN 170 (3-2023)

Clear Fields

Recipient Name:		Medicaid ID Number:	
Recipient Address:	City:	State:	Zip Code:
Telephone Number:			
Destination: To:			
Destination: From:			
Pick Up Time:	Date of Appointment:	Round Trip Yes ☐ No ☐	

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:

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