CPS- Provider Mileage Form

A. Provider

NAME	RESOURCE #
ADDRESS (street/PO box, city, state, zip)	MONTH/YEAR

B. Client

NAME	CLIENT ID #

C. Medical Within Same Zip Code (.65 cents per mile)- Service Code 09-007*

Date	# of Miles (units)	Description	Unit Price	Amount
			$.65/ mile	
			TOTAL	

D. Approved Non-Medical (.65 cents per mile)- Service Code 09-008*

Date	# of Miles (units)	Description	Unit Price	Amount
			$.65/ mile	
			TOTAL	

***Total Amounts from C & D must be placed on CPS-522 Request for Payment (1 Line for each code)**

Provider Signature _____