TEXAS DEPARTMENT OF HEALTH
BUREAU OF KIDNEY HEALTH CARE
1100 W. 49th Street, M-143
Austin, Texas 78756-3184
(512) 458-7796 1-800-222-3986

TRANSPORTATION CLAIM FORM

KHC USE ONLY:
CLAIM #:

Form KHC-3 6/97

A. RECIPIENT IDENTIFICATION: * PLEASE PRINT OR TYPE

Recipient Name: _____ **KHC B#** _____
Last First, Middle Initial

Recipient phone #: _____ **Social Security # (OPTIONAL):** ____ – ____ – ____

B. CLAIM PERIOD: * Only **ONE** month per claim form

Circle the month of this claim: **JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC**
This claim is for the year _____

C. TRAVEL CLAIM:

1. Travel for **IN-CENTER DIALYSIS TREATMENT** only:

IF PERSONAL AUTO USED:

of ROUND trips to dialysis facility this month in your car: _____ **Circle the date of each trip:**

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

# of ONE WAY trips to dialysis facility this month in your car: _____ **Circle the date of each trip:**

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

IF OTHER TRANSPORTATION USED: {cab, bus, special transit}

of ROUND trips to dialysis facility this month: _____ Total fares paid: $_____ **Circle the date of each trip:**

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

# of ONE WAY trips to dialysis facility this month: _____ Total fares paid: $_____

Circle the date of each trip:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

2. Travel for **HOME DIALYSIS AND TRANSPLANT PATIENTS** only:

DATE	NAME & TYPE OF PROVIDER / FACILITY	CITY of Prov./Facil.	REASON FOR TRIP (KIDNEY RELATED)	FARES PAID	MILEAGE

CERTIFICATION: I certify that the above claimed expenses were for allowable travel expenses and I am not eligible for reimbursement for these travel expenses through any other agency. Anyone who falsifies or misrepresents essential information on this form may be subject to prosecution under State Law.

RECIPIENT SIGNATURE: _____
[It is only necessary to sign one side of this form].

WITNESS (IF SIGNED BY AN "X"): _____

Claim Prepared by: _____

THIS FORM MAY BE COPIED

See other side for Drug Claims. ☞