MAINE DEPARTMENT OF HEALTH & HUMAN SERVICES
Transportation Services Mileage Reimbursement

PAY TO: **Full Name:**	
Remit to Mailing Address (must match address on vendor form):	
Vendor #:	**Today's Date:**
Transportation for Client/Person:	
Client A#:	**Case ID:**
Case Name, if different:	
Caseworkers Name:	

Date of Travel & Name of Person Transported	Enter Town to Town to Town	Service Codes: *See Below	R92 Travel Reason:	Actual Miles	Amount @ $.61 per Mile	Other Expenses; Attach receipt

$.61 effective 11/1/2026

				TOTALS:		
					GRAND TOTAL:	

*Service Codes for Transportation: **M92** for visit to MaineCare provider or service; **N92** Visit with the child's parent; or **R92** All Other (must indicate in "R92 Travel Reason")

I am not requesting reimbursement for this transportation from any other public or private entity or organization.

Submitter's Signature
Caseworker's Signature
Supervisor's Signature

NOTE: Travel must be submitted within 60 days of the last date of travel requested on the form. Requests submitted beyond 60 days will not be processed or paid.

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