

<b>AUTHORIZATION – VOUCHER FOR                  MEDICAL, TRAVEL AND INCIDENTAL EXPENSES</b> NEW YORK STATE DEPARTMENT OF HEALTH		RECIPIENT IDENTIFICATION NUMBER	
PATIENT'S NAME			
PAYEE (Name and Address) _____		Period Covered By This Authorization	
		FROM (Mo., Day, Yr.)	TO (Mo., Day, Yr.)
EXPENDITURES			AUTHORIZED \$
<b>TRANSPORTATION</b>  Appointment for _____ . Date ____/____/____  Doctor/Hospital/Clinic (Name and Address) _____ _____ _____  Number of miles traveled per round trip _____    Appointment for _____ . Date ____/____/____  Doctor/Hospital/Clinic (Name and Address) _____ _____ _____  Number of miles traveled per round trip _____			
<b>MISCELLANEOUS</b> (Meals, Lodging, Parking, Tolls, - receipts are required)			
<b>CERTIFICATION</b>  I hereby certify that the amount claimed to be the actual costs incurred by me are just, true, and correct.  X _____ SIGNATURE		<b>TOTAL                  LESS                  AUDIT                  ADJUSTMENT</b>  <b>AMOUNT                  DUE</b>	
		\$	

RECOMMENDED BY	DATE	AUTHORIZED BY	DATE	PAID	Check No.
					Date