TRANSPORTATION INVOICE

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

HFS Use Only

ELITE PICA — TYPEWRITER ALIGNMENT — ELITE PICA

USE CAPITAL LETTERS ONLY

1. Provider Name
2. Provider Number
3. Billing Date
4. Provider Reference
5. Provider Street
6. Provider City State Zip
7. Recipient Name (First, MI, Last)
8. Recipient Number
9. Birthdate
10. Vehicle Lic. #

KKK

11. Service Sections

1. Date of Service | Cat. Serv. | Procedure Code | Prior Approval Number | Orig. Time | Dest. Time | Total Loaded Miles | Provider Charge | Delete X
Orig. Place | Origin (Facility Name/City or Address/City) | Dest. Place | Destination (Facility Name/City or Address/City)

2. Date of Service | Cat. Serv. | Procedure Code | Prior Approval Number | Orig. Time | Dest. Time | Total Loaded Miles | Provider Charge | Delete X
Orig. Place | Origin (Facility Name/City or Address/City) | Dest. Place | Destination (Facility Name/City or Address/City)

3. Date of Service | Cat. Serv. | Procedure Code | Prior Approval Number | Orig. Time | Dest. Time | Total Loaded Miles | Provider Charge | Delete X
Orig. Place | Origin (Facility Name/City or Address/City) | Dest. Place | Destination (Facility Name/City or Address/City)

4. Date of Service | Cat. Serv. | Procedure Code | Prior Approval Number | Orig. Time | Dest. Time | Total Loaded Miles | Provider Charge | Delete X
Orig. Place | Origin (Facility Name/City or Address/City) | Dest. Place | Destination (Facility Name/City or Address/City)

5. Date of Service | Cat. Serv. | Procedure Code | Prior Approval Number | Orig. Time | Dest. Time | Total Loaded Miles | Provider Charge | Delete X
Orig. Place | Origin (Facility Name/City or Address/City) | Dest. Place | Destination (Facility Name/City or Address/City)

6. Date of Service | Cat. Serv. | Procedure Code | Prior Approval Number | Orig. Time | Dest. Time | Total Loaded Miles | Provider Charge | Delete X
Orig. Place | Origin (Facility Name/City or Address/City) | Dest. Place | Destination (Facility Name/City or Address/City)

7. Date of Service | Cat. Serv | Procedure Code | Prior Approval Number | Orig. Time | Dest. Time | Total Loaded Miles | Provider Charge | Delete X
Orig. Place | Origin (Facility Name/City or Address/City) | Dest. Place | Destination (Facility Name/City or Address/City)

8. Date of Service | Cat. Serv. | Procedure Code | Prior Approval Number | Orig. Time | Dest. Time | Total Loaded Miles | Provider Charge | Delete X
Orig. Place | Origin (Facility Name/City or Address/City) | Dest. Place | Destination (Facility Name/City or Address/City)

12. TPL Code | Status | TPL Amount | TPL Date
12. TPL Code | Status | TPL Amount | TPL Date

13. Uncoded TPL Name

14. # Sects

15. Total Charge

16. Total Deductions

17. Net Charge

My signature certifies that; all entries on this claim are true, accurate and complete; the State's Medical Assistance Program pricing limits will be accepted as payment in full; any payments received from the patient or any other third party will be properly credited or paid to the Illinois Department of Healthcare and Family Services; program clients will not be billed for the difference between charges and State pricing limits; records necessary to fully disclose the nature and extent of services provided are maintained and will be made available upon request of State and Federal officials responsible for the various aspects of the State's Medical Assistance Program, as provided under Title XIX of the Social Security Act and applicable State statutes; if billing as an individual practitioner, I provided or directly supervised all services for which a charge appears; I am duly authorized as a representative of the entity to be reimbursed by this claim; I understand payment is made from State and Federal funds and that any falsification or concealment of material fact may lead to appropriate legal action; in compliance with the Civil Rights Act of 1964, services were provided without discrimination on the grounds of race, color or national origin; and handicapped persons are afforded the rights and considerations specified in Section 504 of the Rehabilitation Act of 1973 and Part 84 of the Code of Federal Regulations.

Completion mandatory, 305 ILCS 5/1-1 et. seq., penalty non-payment.

Form has been approved by the Forms Management Center.

HFS 2209 (R-7-05)

Provider Signature (DO NOT USE RUBBER STAMP) Date

IL 478-1019