ORANGE COUNTY DEPARTMENT OF HEALTH
PRESCHOOL & EARLY INTERVENTION
PARENT TRANSPORTATION
BILLING FORM

PARENT'S NAME:_____

CHILD'S NAME:_____

SERVICE MONTH/YEAR____ ___/____ ____ **TR#_____ PURCHASE ORDER # _____**

NAME OF PROGRAM/PROVIDER TRANSPORTING TO: _____

PROGRAM/PROVIDER ADDRESS:_____

DATE	SERVICE PROVIDER SIGNATURE		DATE	SERVICE PROVIDER SIGNATURE

TOTAL NUMBER OF DAYS:	DAILY RATE:	TOTAL AMOUNT OF CLAIM:

By signing this form, I attest to the fact that the dates above are the actual dates I transported my child for services.

PARENT SIGNATURE:_____ DATE: _____

PLEASE MAIL FORM WITH ORIGINAL SIGNATURES TO:
PrismaticSBL
680 Route 211E
3B #156
Middletown, NY 10941