

ND RYAN WHITE PROGRAM PART B REQUEST FOR TRANSPORTATION REIMBURSEMENT

NORTH DAKOTA DEPARTMENT OF HEALTH DIVISION OF DISEASE CONTROL

SFN 58584 (11-2013)

Client's Name	ND Ryan White Client Number
Date Form Completed	
Instructions	
 The signature of your service provider must be obtained to confirm your appointment. Return this completed form to your case manager. 	
City of Residence	Date(s) of Travel
City of Destination	Miles Traveled
Bus Fare	
Explanation of Travel	
Type of Appointment	
☐ Infectious Disease Doctor ☐ General Pro	actitioner
Pain Doctor Other Physician's Name (please print)	Telephone Number
Appointment Verification	
7 ppolitiment vermedien	
Health Care Provider's Signature	Date
Signatures	
Client's Signature	Date
Casa Managar's Signature	
Case Manager's Signature	Date