AUTHORIZATION FOR BILLING Vendor # _____

Client Name: _____ **Address:** _____ _____	**Case Number:** _____ **Program:** _____
Driver's Name: _____ **Address:** _____ _____ ☐ **Check if this is different address.**	**Period of Authorization:** **From:** _____ **Through:** _____
Date of Authorization: _____	**Authorized by:** _____

DATE & APPT TIME	NUMBER OF MILES ROUND TRIP TO NEAREST WHOLE MILE	ITEMIZED ACCOUNT	CLINIC/ HOSPITAL AUTHORIZED SIGNATURE	AMOUNT DUE	Office
		FROM: _____ City State TO: _____ Doctor Clinic Hospital _____ City State			
		FROM: _____ City State TO: _____ Doctor Clinic Hospital _____ City State			
		FROM: _____ City State TO: _____ Doctor Clinic Hospital _____ City State			

I hereby acknowledge that I have received the goods on this billing: X_____ Client's Signature	I declare under the penalties of law that this account claim, or demand, is just and correct and that no part of it has been paid: X_____ Driver's Signature	Worker Initial and Date: _____ _____

RETURN THIS FORM BY THE 5TH OF THE MONTH FOR PAYMENT TO BE ISSUED ON THE 17TH.

RETURN TO: Douglas County Social Services, 809 Elm Street, Suite 1186, Alexandria, MN 56308

Reminder: Prior authorization for services must be obtained for services outside the local trade area (120 miles from Alexandria).