NEIGHBORHOOD HEALTH PROVIDERS

P.O. Box 6008, Hauppauge, NY11788

Authorization and Receipt for Medical Care Transportation

Date	Patient Cin Number	Patient DOB	Patient Last Name PLEASE PRINT	Patient First Name PLEASE PRINT	Patient or Parent/ Legal Guardian Signature	Number of Metrocards	Total $ Amount

Total Metrocards:_____

I certify that I paid the amount shown for transportation expenses to the above NHP members.

Name of office/center_____ **Authorized by_____** **Title_____** **Date_____**

Address:_____

Tax ID #:_____