County of Lake California Children's Services
Maintenance and Transportation (M & T) Provider Claim Form

Claim must be submitted within 45 days of date of service or hospital discharge. Late claims will be denied.
Submit to: Lake County CCS, 922 Bevins Ct., Lakeport, CA 95453 or Fax: (707)263-5872

Claimant/Pay to: _____

Mailing Address: _____

_____

Verification of Services

Child's Name: _____ DOB: _____

Date of Service or Hospital Admission: _____Discharge Date: _____

Medical Provider/Specialty: _____

Phone Number: _____ Location of Provider (City):_____

- **Services MUST be covered under an approved and current Service Authorization Request (SAR)**

Meals – attach UB1500/Invoice/Bill:

☐ One Parent/Legal Guardian ☐ Two Parents/Legal Guardians ☐ Client

Number of Days_____ x $ 15 = $_____

Lodging – attach UB1500/Invoice/Bill:

Number of Days_____ x $_____ = $_____

Public Transportation (Receipt must be attached)

☐ Taxi/Uber/Lyft ☐ Greyhound Bus Ticket ☐ Other _____ = $_____

Total Reimbursement Claimed: $_____

I certify under the penalty of perjury that the within claim and the items as therein set out are true and correct, that no part thereof has heretofore been paid and that the amount therein is justly due me and that the same is presented within 45 days of date of service or hospital discharge inclusive of required receipts.

_____

Claimant's Signature **Date**