

Public Partnerships, LLC
P.O. Box 5157
Charleston, WV 25361
Phone: (866) 429-3465
Fax: (866) 388-1626



EMPOWERING
PEOPLE'S HEALTH

**West Virginia Personal Options
Aged And Disable Waiver Program
Transportation Invoice**

Instructions:

1. This invoice must be completed and submitted **each pay period**. Please do not put dates for more than one pay period on a single invoice. If more space is needed for a single pay period, use additional sheets as needed. Make sure transportation is reflected on Monthly Homemaker Documentation form.
2. The participant/employer must review, approve, and sign the invoice.
3. The invoice must be faxed to (866) 388-1626 or
Mail to: Public Partnerships, LLC, P.O. Box 5157 Charleston, WV 25361

Participant Name: _____		Participant ID#: _____		
Employee Name: _____		Employee ID#: _____		
Pay Period Start Date: _____		Pay Period End Date: _____		
Service Code: A0160				
Rate: _____ (The maximum rate is defined by West Virginia Bureau for Medical Services)				
Date:	Miles Driven:	Travel Time (hrs):	Destination:	Purpose of Travel:
Total:				
Signatures:				
I verify that I have a current valid driver's license and motor vehicle insurance as required by West Virginia State Law and that the billing for services provided is accurate and complete.				
Employee Signature: _____		Date: _____		
Participant Signature: _____		Date: _____		