Managed Care Referral

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Medical Assistance
Transportation Program

Recipient Identification				
Last Name:	First Name:		Initial:	Date of Birth:
SSN:	MA Recipient #:		Phone #:	
Street Address:			Apartment #:	
City:	Municipality:	County:	State:	Zip:
Emergency Contact:		Relationship:	Phone #:	
Does this recipient speak English? ☐ Yes ☐ No	If no, what language is spoken?			
Will this recipient need to travel with an interpreter? ☐ Yes ☐ No				

Is this a non-emergency medically necessary (ambulance) transportation referral? ☐ Yes ☐ No

This need is: ☐ Permanent ☐ Temporary

Please fully describe the reasons for this referral below:

Next Appointment Date:	Next Appointment Time:			
Provider or Practice Name:			Phone #:	
Street Address:				
City:	Municipality:	County:	State:	Zip:

Is this a request to assist MATP with delivery of transportation services? ☐ Yes ☐ No

Can transportation be provided pending resolution? ☐ Yes ☐ No

☐ Requested medical provider/service is outside operating area/hours of the MATP.

☐ Temporary conditions/circumstances prevent transportation.

Please fully describe the reasons for this referral below:

MATP Referral Information:

Referred by:

Telephone:

Date: