Mileage Reimbursement Request - Complete One Form for Each Medical Service Provider

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Medical Assistance Transportation Program

Patient

Last Name:	First Name:	Initial:
MA Recipient #: ***OR***	SSN:	Phone #:

Parent/Guardian/Head of Household (If Different than Patient Listed Above)

Last Name:	First Name:	Initial:
MA Recipient #: ***OR***	SSN:	Phone #:

Address - Complete only if your address has changed

Street Address:				Apartment #:
City:	Municipality:	County:	State:	Zip:

Medical Provider Address

Provider or Practice Name:				Phone #:
Street Address:				
City:	Municipality:	County:	State:	Zip:

Type of Medical Facility or Service Provider (Please Check One)

☐ Doctor's Office	☐ Hospital	☐ Pharmacy	☐ Dialysis Clinic	☐ Mental Health Facility
☐ Dental Office	☐ Lab Work	☐ Medical Supply	☐ Methadone Clinic	☐ STAP (Summer Camp)
☐ Chiropractor	☐ Medical Supply	☐ Physical Therapy	☐ Drug & Alcohol Facility	☐ Other

I hereby certify that to the best of my knowledge, the medical trip information listed on the back of this form is true, correct, and complete. I agree to report any changes in circumstances immediately to the MATP Service Provider. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and that giving knowingly false statements is a criminal offense. I understand that I have a right to request a Department of Human Services fair hearing if benefits are denied. This affirmation statement covers all attachments required for the determination of eligibility.

Signature of Recipient, Guardian, or Head of Household

Date Signed

FOR OFFICE USE ONLY

Eligible on Trip Dates? ☐ Yes ☐ No	Verified By:	Date Verified:	Total Mileage From Back:	X .12 =
Mileage Verified? ☐ Yes ☐ No	Attendance Verified? ☐ No ☐ All ☐ Random	Verified By:	Tolls: (Provide Receipts)	
Total Amount of Payment:	Check Number:	Payment Issue Date:	Parking: (Provide Receipts)	
			Total Reimbursement This Form:	

Mileage Reimbursement Request - Appointments

Each Medical Service Provider Must be Placed on a Separate Form

Medical Service Providers - Your signature verifies the patient shown on the front of this form received an MA eligible medical service(s) in your facility on the date(s) listed. You must sign to verify each appointment if multiple appointments are listed.

Appointments						
Appointment Date	**Appointment Time**	**Signature of Medical Provider**	**Time Signed**	**Parking**	**Tolls**	**Round Trip Miles**