



MEDICAL ASSISTANCE TRANSPORTATION PROGRAM
Client Mileage and Verification Form

P.O. BOX 339, Scotrun, PA 18355

(570) 839-6282 • Fax (570) 839-8205

PLEASE DO NOT USE THIS FORM FOR MORE THAN ONE (1) TRIP
Forms that are over 30 days "WILL NOT" be considered for reimbursement.

Name of Client: _____ MA ID Number: _____

Has your address changed No Yes If yes, complete the next two lines

Physical Address (no P.O. Boxes) _____

Mailing Address _____

Date of Appointment: _____ Time of Appointment: _____

Doctor Information (Name) _____
(Name of Doctor or Facility & Specialty or Type) (I. E. Cardiologist, Endocrinologist)

Destination Address & Phone # _____

Trip mileage: _____ *(Google maps are used to verify miles)*

Parking \$: _____ Tolls \$: _____ *(Receipts required)*

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VERIFICATION BY MEDICAL PROVIDER
(This section is to be completed by Doctors office only)

"Medical Service Provider: Your signature verifies that the patient shown above received an MA eligible medical service(s) in you facility on the date listed. You must sign to verify each appointment."

Physician/Facility Printed Name: _____

Physician/Facility Signature: _____

Physician Address: _____
(Please include complete address & phone number of facility)

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"I hereby certify to the best of my knowledge, the medical trip information submitted on this form is true, correct, and complete. I agree to report any changes in circumstances immediately to the MATP Service Provider. I understand documentation of all eligibility factors may be required to determine eligibility correctly of for auditing purposes and giving knowingly false statements is a criminal offense. I understand 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 and MA service verification" False statements are a criminal offense. Please ensure that the above information can be verified by the MATP claims processor on behalf of the Department of Human Services. Please have the doctor, pharmacist, nurse or receptionist sign the verification above before leaving the office or provide some other type of verification. Failure to provide accurate information may result in transportation benefits being suspended.

Client/Guardian Signature: _____ Phone# _____

Form completion/submission Date: _____