



MEDICAL ASSISTANCE TRANSPORTATION PROGRAM
MILEAGE REIMBURSEMENT
MULTIPLE TRIPS

Forms must be received within 30 calendar days of the date of service

PART I: Incomplete, illegible, or late forms will result in delayed or denied payment.

Client Name: _____ Date of Birth: _____
Address: _____ Phone: (____) _____
MA Card #: _____
Social Security #: _____ Age: _____

PART II: Please complete one form for each medical provider seen. Do not use if attending an appointment on ONE date of service.

1) Type of Facility: (Check One)

- Doctors Office, Hospital, Dental Office, Chiropractor, Lab Work, Mental Health Facility, Pharmacy, Medical Supply, Dialysis Clinic, Physical Therapy, Drug & Alcohol Facility, Methadone Clinic, Mental Health Summer Camp

You MUST include the COMPLETE ADDRESS of the Medical Provider who saw you.

Doctor or Facility Name: _____
Doctor or Facility Address: _____
(Not Building Name) _____
Doctor or Facility Phone: (____) _____

2) Miles (Round Trip): _____

3) Parking/Toll Expense - Original receipts MUST be attached and must include the name of the Parking Lot or Toll Road, plus the Date and the Amount Paid. Non-Originals (copies) will not be accepted.

3a) Parking Expense: \$ _____ 3b) Toll Road Expense: \$ _____

4) TOTAL: #2 Miles x \$0.12 = _____ + #5a Parking + #5b Toll Road = _____

NOTE: The mileage you are claiming will be verified by the MATP office using an internet mapping software as well as the availability of bus transportation along the route you travel. Your request for reimbursement will be paid based on that information.

I certify that the information presented here is true and correct to the best of my knowledge.

Client Signature: _____

NOTE: Client Reimbursement will not be processed without the Client's and Provider's Original signature and MA Number. (Copies/Faxes WILL NOT be accepted)

