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:** _____

Phone #: _____ **MA Card #:** _____

☐ **Address Change of Information:** If there has been a permanent or temporary change to the address from which mileage is calculated, please update your information here.

_____

_____

1. Date of Trip: _____ **2. Appointment Time:** _____(AM/PM) **3.Miles**(Roundtrip)**:**_____

4. Type of Facility:

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

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: (_____)_____

5.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. Exceptions will be made to the 30-day deadline for cashless toll charges.

Non-Originals (copies) will **NOT** be accepted.

Parking Expense: $_____ **Toll Road Expense: $**_____

6. #3 (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 and faxes **WILL NOT** be accepted.

PART III: MEDICAL PROVIDER VERIFICATION (To be filled out by the Medical Provider Only)
I hereby verify that the above client was seen in this medical facility for services to be covered by the client's Medical Assistance. This facility accepts such payment as a Welfare Compensable Provider under the number listed below.

13 Digit MA Provider Number: _____

Each line MUST be completed by a medical assistance provider or representative.

Today's Date	Appt Time	Service Date	Signature and Title

Mail or drop this form off at: GO Westmoreland
41 Bell Way
Greensburg, PA 15601

You can obtain forms by:

- Calling the MATP office to have forms mailed to you.
- Check the Westmoreland Transit website: http://www.westmorelandtransit.com

Questions? Call the MATP Office **1-800-242-2706** (toll free)