MEDICAL ASSISTANCE TRANSPORTATION PROGRAM
MILEAGE REIMBURSEMENT

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.

_____

_____

PART II:

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

4.Type of Facility:

☐ Doctors Office	☐ Mental Health Facility	☐ Physical Therapy
☐ Hospital	☐ Pharmacy	☐ Drug & Alcohol Facility
☐ Dental Office	☐ Medical Supply	☐ Methadone Clinic
☐ Chiropractor	☐ Dialysis 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.

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: THIS PORTION TO BE COMPLETED BY THE ENROLLED WELFARE COMPENSABLE 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.

MA Provider #: _____ **Date Client Received Services:** _____

Signature: _____ **Today's Date:** _____

Printed Name & Title: _____ **Time of Appointment:** _____AM/PM

Please read carefully- PAYMENT CANNOT BE PROCESSED IF INFORMATION IS INCOMPLETE, ILLEGIBLE, LATE, OR ALTERED

Instructions

Front side of the form: PART I

1. Print the name, date of birth, phone number, and note any changes of address of the person (client) with the medical appointment.
2. Enter the client's ten-digit Medical Assistance number (recipient number) from the ACCESS card or the Member # or ID # from the insurance card.
3. The client with the medical appointment must sign by "Client Signature." If the client is under the age of 18, a parent or guardian must sign.

Front side of the form: PART II

1. Write in the number of miles for the round trip.
2. In the box, check the type of facility you visited and print the name, address, and phone number.
3. List any parking or toll road expenses for which you have receipts

Back side of the form: PART III

Have your medical service provider read and complete the section on the back of this form. They must verify the date and time that services were provided. We will not accept forms with an altered date, time, or signature.

REQUIREMENTS

1. A separate form must be used for each medical provider.
2. When picking up a prescription, medical supplies or equipment, PART I and PART II of the form must be filled out completely for the period you are turning in. You can attach multiple pharmacy receipt(s) to a single form; the provider does not have to sign the mileage form if a valid receipt(s) are attached.
3. MATP will reimburse mileage as shown in PART II, or the mileage as determined by MATP staff using an internet mapping software.
4. MATP will reimburse for parking and/or toll road expenses with original, dated receipts ONLY.
5. Mileage reimbursement will be only from the client's home address to the medical provider and back. Additional mileage for side trips, shopping, detours, etc. will not reimbursed.
6. When two or more clients travel to the same medical provider, at the same time, using the same vehicle, the trip will be split between the two clients.

Mail or drop this form off at: Westmoreland Transit-MATP Office

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)