M.A.T.P - MEDICAL ASSISTANCE TRANSPORTATION PROGRAM REIMBURSEMENT REQUEST

Potter County Human Services
62 North Street, P.O.Box 241, Roulette, PA 16746
Phone: (814) 544-7315 or 800-800-2560

***** PROCESSOR MUST BE ABLE TO READ ALL INFORMATION ON THIS FORM OR IT WILL BE RETURNED TO RECIPIENT FOR CLARIFICATION *****

NAME: _____ **RECIPIENT #:** _____

(MUST PRINT RECIPIENT NAME ABOVE)

☐ **PLEASE CHECK THIS BOX IF YOUR ADDRESS HAS CHANGED. PLEASE PROVIDE NEW ADDRESS ON THE BACK OF THIS FORM**

1. DATE AND TIME	2. MEDICAL PROVIDER	3. LOCATION/ADDRESS AND PHONE NUMBER	4.MILES/ PARKING/ TOLLS	5. MA ELIGIBILITY	6. MEDICAL PROVIDER'S SIGNATURE AND DATE
				yes ___ no ___	
				yes ___ no ___	
				yes ___ no ___	
				yes ___ no ___	
				yes ___ no ___	
				yes ___ no ___	
				yes ___ no ___	
				yes ___ no ___	
				yes ___ no ___	
				yes ___ no ___	

****"I hearby 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 Provider. I understand documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and giving knowlingly 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."****

"Medical Services Provider - Your signature verifies that the patient shown on the 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."

_____ _____ _____

Date Printed Name Signature

Official Use Only

Total Miles: _____
Tolls: _____
Parking: _____
Total Trips: _____
Amount: $_____
Pages: _____

Official Use Only

Verification# _____ Date: _____ Category: _____ Program Status: _____

Eligibility Verified By: _____