

Mileage Reimbursement Request - Complete One Form for Each Medical Service Provider



Patient			
Last Name:	First Name:	Initial:	
MA Recipient #:	<i>OR</i>	SSN:	Phone #:

Parent/Guardian/Head of Household (If Different than Patient Listed Above)			
Last Name:	First Name:	Initial:	
MA Recipient #:	<i>OR</i>	SSN:	Phone #:

Address - Complete only if your address has changed				
Street Address:				Apartment #:
City:	Municipality:	County:	State:	Zip:

Medical Provider Address				
Provider or Practice Name:				Phone #:
Street Address:				
City:	Municipality:	County:	State:	Zip:

Type of Medical Facility or Service Provider (Please Check One)				
<input type="checkbox"/> Doctor's Office	<input type="checkbox"/> Hospital	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Dialysis Clinic	<input type="checkbox"/> Mental Health Facility
<input type="checkbox"/> Dental Office	<input type="checkbox"/> Lab Work	<input type="checkbox"/> Medical Supply	<input type="checkbox"/> Methadone Clinic	<input type="checkbox"/> STAP (Summer Camp)
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Medical Supply	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Drug & Alcohol Facility	<input type="checkbox"/> Other <input style="width: 100px; height: 20px;" type="text"/>

I hereby certify that to the best of my knowledge, the medical trip information listed on the back of this form is true, correct, and complete. I agree to report any changes in circumstances immediately to the MATP Service Provider. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and that giving knowingly false statements is a criminal offense. I understand that 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.

Signature of Recipient, Guardian, or Head of Household

Date Signed

FOR OFFICE USE ONLY					
Eligible on Trip Dates?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Verified By:	Date Verified:	Total Mileage From Back:	X .12 =
Mileage Verified?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Attendance Verified?	<input type="checkbox"/> No <input type="checkbox"/> All <input type="checkbox"/> Random	Verified By:	Tolls: (Provide Receipts)
Total Amount of Payment:	Check Number:	Payment Issue Date:			Parking: (Provide Receipts)
					Total Reimbursement This Form:

