# INDIANA COUNTYDEPARTMENT OF HUMAN SERVICES-MATP OFFICE

**300 INDIAN SPRINGS ROAD, SUITE 203 INDIANA, PA 15701**
**(742) 463-3235 OR 1(888) 526-6060 EXT. 5 TDD/TYY: (724) 465-3805**

**Incomplete, altered, illegible, or late forms will result in delayed or denied payment.**

**Part I:**
**Client Name**: _____ **Date of Birth**: _____ **MA Card #**: _____

**Address**: _____ **Phone**: (_____)_____

_____ ☐ Check box if your address has changed

**PART II:**
**Date of Trip**: _____ **Appointment Time**: _____ AM/PM **Miles (Roundtrip)**: _____ ☐ mileage verified (office use only)

**COMPLETE ADDRESS** of the Medical Assistance Provider who saw you.

**MA Provider or Practice Name**: _____
**MA Provider Address:** _____
***(Do not Put Building Name)*** _____
**MA Provider Telephone**: ( _____ ) _____

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

**Note:** The MATP Office calculates mileage using Internet mapping software

***I hereby certify to the best of my knowledge, the medical trip information submitted on this form is true, correct and complete. I have not carpooled with anyone is also submitting for mileage reimbursement and I am submitting mileage reimbursement from my legal residence to the MA provider. I agree to report any changes in circumstances immediately to the MATP Service Provide. I understand documentation for all eligibility factors may be required to determine eligibility correctly or for auditing purposes and giving knowing 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.***

**Client Signature**: _____

**PART III:**

***THIS PORTION IS TO BE COMPLETED BY THE ENROLLED WELFARE COMPENSIBLE 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 Compensible Provider under the number listed below.**

**Med. Assistance Provider Number**: __ _____ **Date Client Received Services**: _____
**(MUST BE 13 DIGITS)**
**Signature**:_____ **Today's Date**: _____

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

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**OFFICE USE ONLY**

**Consumer eligible on trip date: ☐ Yes or ☐ No** **Verified By: _____** **Trip Attendance Verified: ☐ Yes or ☐ No**

**Reimbursement calculations verified: ☐ Yes or ☐ No** **Check#: _____** **Payment Issued Date: _____**