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**: (_____)_____ Preverification Code:_____

_____ ☐ 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

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: _____**