



INDIANA COUNTY DEPARTMENT OF HUMAN SERVICES-MATP OFFICE



Please complete one form for patient and each medical provider.
Do not use if attending an appointment on only one date of service.
Incomplete, altered, illegible, or late forms will result in delays or denied payment.

Part I

Client name _____ Date of Birth _____

Address: _____ Phone: _____

_____ MA #: _____

Check box if your address/phone has changed Preverification Code: _____

Part II

Please provide complete address of medical provider.

MA Provider/Facility Name: _____

MA provider/Facility Address: _____

MA Provider Phone: _____

Miles (round trip) _____ Mileage Verified (office use only)

Parking/toll expenses-must attach receipt verifying name of parking garage or toll road, date and amount paid. MATP will calculate mileage using Internet mapping software.

Parking Expense: _____ Toll Road Expense: _____

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 who is also submitting for mileage reimbursement. I agree to report any changes in circumstances immediately to the MATP Service Provider. I understand documentation for all eligibility factors may be required to determine eligibility correctly or for auditing purposes and giving knowingly 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: _____

OFFICE USE ONLY

Consumer eligible on trip date: Y/N Trip Attendance Verified: Y/N Verified By: _____

Reimbursement calculations verified: Y/N Payment Date: _____ Check #: _____

