INDIANA COUNTYDEPARTMENT 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.**

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 #:** _____

PART III:

THIS PORTION IS TO BE COMPLETED BY THE ENROLLED WELFARE COMPENSIBLE PROVIDER ONLY

I hereby verify that the 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 Compensable Provider under the number listed below.

Med. Assistance Provider Number: _____ **(MUST BE 13 DIGITS)**

TODAYS DATE	APPT TIME	DATE RECEIVED SERVICES	SIGNATURE AND TITLE

Questions?? Call the MATP Office: 724-463-3235 or 1-888-526-6060 – Ext 5 TDD/TYY: 724-465-3805

Mail or drop this form off to: Indiana County Department of Human Services – MATP Office
300 Indian Springs Road, Suite 203
Indiana, PA 15701