FULTON COUNTY FAMILY PARTNERSHIP

22438 Great Cove Rd.
McConnellsburg, PA 17233
717-485-6767
888-329-2376 toll free
Fax 717-485-4505
www.fcfpinc.org

MEDICAL ASSISTANCE TRANSPORTATION PROGRAM

Directions:

1. This form is to be used solely for the purpose of requesting reimbursement for transportation expenses to and from a source of necessary medical care. You must be receiving a medical assistance (Medicaid) eligible service to receive reimbursement. **HAVE THE FORM SIGNED** by your doctor or another authorized individual within the medical facility in order to verify that you received treatment on the date listed. **The MEDICAL ASSISTANCE PROVIDER NUMBER MUST ALSO BE WRITTEN IN THE SAME BLOCK AS THE SIGNATURE.**
2. Payment will be made at the rate of $0.25 per mile. Special cases with frequent long distance trips will be referred to the County Assistance Office for reimbursement.
3. Your request for reimbursement (this form) must be sent to the Fulton County Family Partnership, Inc. at the address listed above in order for checks to be processed. **YOU ARE RESPONSIBLE FOR SUBMITTING COMPLETED FORMS.** Incomplete forms will be returned unprocessed.
4. You will only be reimbursed for one trip to the same town per day. You will only be reimbursed for two trips to the pharmacy per week. Trips for family members must be consolidated.
5. Pharmacy trips are limited to your choice of two pharmacies closest to your home address or the pharmacy closest to your medical provider's office if completed with your medical visit. You may go to a more distant pharmacy if you can provide us medical verification that it is necessary.
6. Trips to an Emergency Room are not eligible for reimbursement.
7. If you have toll or parking expenses, please attach receipts to be reimbursed for those expenses.
8. Please be sure to complete **ALL** information requested on this form and return it to our office as promptly as possible so that we may better serve you.
9. To guarantee processing, turn forms in within fifteen days of the date of the trip. You will not be compensated for trips that occurred more than 30 days prior to the submission of this form.
10. Reimbursement checks will only be issued with the total amount reaches or exceeds ten dollars ($10.00).
11. Reimbursement checks will be mailed. Our office will process forms regularly (at least monthly). Checks will be available at the discretion of the business office.

If you have any questions, please call the number listed above, and ask for the MATP coordinator.

I hereby certify to the best of my knowledge, the medical trip information submitted on this form is true, correct, and complete. I agree to report any changes in circumstances immediately to the MATP Service Provider. I understand documentation of all 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.

Signature _____ Date _____

Client Name: _____ MA ID Number: _____

Client's Address: _____ DOB: _____

FOR OFFICE USE ONLY

Total Miles: _____ X $0.25 = $_____

Payment made to: _____

In the amount of: $_____ on _____

Comments:

Form updated on 11-15-23

SAMPLES:

Provider: Fulton Co. Medical Center Dr/Dept: Lab Town: McConnellsburg Phone: 717-485-3155	Provider: Tri– State Com. Dr/Dept: DeShong Town: McConnellsburg Phone: 717-485-3850	Provider: Keystone Women's Care Dr/Dept: Brown Town: Chambersburg Phone: 717-217-6830	Provider: McLaughlin's Pharmacy Dr/Dept: Town: McConnellsburg Phone: 717-485-3824

Appointment Date and Time	Provider - Name of practice, Doctor/Department, Town & Phone # (see samples above)	Person(s) treated	Miles round trip	Authorized signature or Approved Stamp & Medical Assistance Provider Number
	Provider:__________ Dr./Dept:__________ Address: __________ Phone: __________			
	Provider:__________ Dr./Dept:__________ Town: __________ Phone: __________			
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	Provider:__________ Dr./Dept:__________ Town: __________ Phone: __________			

Medical Service Providers-Your signature verifies that the patient shown on the front of this form received an MA eligible medical service(s) in your facility on the date(s) listed. You must sign to verify each appointment if multiple appointments are listed.

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