



113 South 2nd Street
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) benefits 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 involving exceptional transportation (such as lodging, meals, airfare, and traveling exceptionally far distances) 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.** For any incomplete forms FCFP will attempt at least one time to contact you before denying the trip(s). If a trip is denied a formal written notice will be issued.
4. 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.
5. If you have toll or parking expenses, please attach receipts to be reimbursed for those expenses.
6. 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.
7. To guarantee processing, turn forms in for a month no later than 15 days from the start of the next month. You will not be compensated for trips that occurred more than 30 days prior to the submission of this form unless approved by the Transportation Coordinator.
8. Reimbursement checks will only be issued with the total amount reaches or exceeds ten dollars (\$10.00).
9. 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:

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: _____			
	Provider: _____ Dr./Dept: _____ Town: _____ Phone: _____			
	Provider: _____ Dr./Dept: _____ Town: _____ Phone: _____			
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	Provider: _____ Dr./Dept: _____ Town: _____ Phone: _____			
	Provider: _____ Dr./Dept: _____ Town: _____ Phone: _____			
	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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