MEDICAL ASSISTANCE TRANSPORTATION PROGRAM - CLIENT REIMBURSEMENT REQUEST

MONTH_____**, 201**_____ **ACCESS CARD (RECIPIENT NUMBER)**_____

Consumer Name:_____ **Social Security Number:_XXX-XX-**_____ **Date of Birth:**_____
Home Address:_____ **City and State, Zip:**_____ **Phone #:**_____

Mailing address (if different from Home Address):_____

***** Must provide full address***** *****Write in Bus Route # if using Public Transportation*** ***No Stamps or Initials***

Date:	****Name & Full Address of Treatment Provider** (Street Address and City)	**Total** Miles Traveled	**Public Transportation** (Fare, Parking, Tolls)	**PRINTED** Name of Authorized Treatment Provider	**SIGNATURE** of Provider

Date:	**Name & Full Address of Treatment Provider**	**Total** Miles	**Public**	**PRINTED**	**SIGNATURE**

	(Street Address and City)	Traveled	**Transportation** (Fare, Parking, Tolls)	Name of Authorized Treatment Provider	of Provider

Total Number of Miles Traveled:_____ Mileage Reimbursement ($0.12 per mile):$_____

Parking and Tolls: $_____ Public Transportation Fare: $_____ Total Reimbursement Request: $_____

I certify that the information on this form is a true, correct and accurate record of my transportation to and/or from a Medical Assistance Compensable Treatment Provider. I have read the mileage and Public Transportation Reimbursement Policy included in my initial application packet and understand all of the rules and requirements of the Medical Assistance Transportation Program. I am aware that knowingly ***or intentionally making a false statement of representation of a material fact in an application or a Medical Assistance benefit or reimbursement is considered fraud and can lead to loss of benefits fines and possible criminal prosecution.***

_____ _____

Consumer Signature Date of Signature

Please return this completed and signed form to: Rover Community Transportation, 1002 S. Chestnut St. Downingtown, PA 19335, no later than the last day of the month in which the services were received.