



MATP REIMBURSEMENT FORM

Consumer ID # _____

CONSUMER NAME: _____

ADDRESS: _____

To Medical Assistance Cardholder:

- If you have a car available, or if you know someone who has a car and can take you to your medical appointment, we will provide you mileage reimbursement if it is the least costly, most appropriate service available. We will reimburse you at the rate of **25 cents per mile**. We will also reimburse you for your actual parking expenses and tolls if you provide receipts showing how much you paid.
- A check will be sent to you on the 15th of the month, along with reimbursement form for the following month. We **cannot** reimburse beyond 60 days, the maximum reimbursement you can receive is 60 days. **Retroactive reimbursements will NOT be honored.**
- If your address and/or telephone number has changed, please notify us at 610-490-3975 prior to mailing in this form.
- **Original receipts must be attached for Mass Transit trips to receive payment. No photocopies will be accepted.**

FACILITY ATTENDING:

Please complete the other side of this application if you travel to more than one medical facility or pharmacy. If additional forms are needed, please call our office.

SEPTA ROUTE: _____

OR

MILES DRIVEN PER DAY ROUND TRIP: _____

MONTH REQUESTING REIMBURSEMENT: _____

(1 Month per form)

DATE ATTENDED FACILITY

Indicate which days you at the above medical facility for the month by placing **your initials** on the line next to the appropriate date.

01 _____	09 _____	17 _____	25 _____
02 _____	10 _____	18 _____	26 _____
03 _____	11 _____	19 _____	27 _____
04 _____	12 _____	20 _____	28 _____
05 _____	13 _____	21 _____	29 _____
06 _____	14 _____	22 _____	30 _____
07 _____	15 _____	23 _____	31 _____
08 _____	16 _____	24 _____	

TO THE AUTHORIZED SIGNER:

I certify that the above named patient received medical services at the facility on the dates listed above, and the client presented a current, Medical Assistance Access Card.

Signature: _____

Title: _____

Address: _____

Phone: (_____) _____

Date Authorized: ____/____/____

- **Pre-authorized forms will NOT be accepted. The last date that is eligible, is that date on which the reimbursement has been authorized.**

FORMS MUST BE MAILED TO:
 COMMUNITY TRANSIT OF DELAWARE COUNTY
 206 Eddystone Avenue
 Suite 200
 Eddystone, PA 19022
 610-490-3975

Office Staff Only

Miles	Mode	Trips	Amount	Approval



**Medical Assistance Transportation Program
Reimbursement Request**

Consumer ID # _____

Consumer Name: _____
Address: _____

TO MEDICAL ASSISTANCE CARDHOLDER:

- If you have a car available, or if you know someone who has a car and can take you to your medical appointment, we will provide you mileage reimbursement if it is the least costly, most appropriate service available. We will reimburse you at the rate of **25 cents per mile**. We will also reimburse you for your actual parking expenses and tolls if you provide receipts showing how much you paid.
- A check will be sent to you on the 15th of the month, along with reimbursement form for the following month. **We cannot reimburse beyond 60 days. The maximum reimbursement you can receive is 60 days. Retroactive reimbursements will NOT be honored.**
- If your address and/or telephone number has changed, please notify us at 610-490-3975 prior to mailing in this form.
- **Original Receipts must be attached for Mass Transit payment. No photocopies will be accepted.**

Community Transit MATP
206 Eddystone Avenue
Suite 200
Eddystone, PA 19022

To the Authorized Signer: Your signature on this form indicates that this client has received Medical-reimbursable services from you, at your facility, you signed the form on the date indicated, and they presented a **current ACCESS** card to you.

Please Print Clearly

Visits	Dates	Facility	Address and Telephone #	SEPTA Rte #	Vehicle Mileage	Authorized Signature/ Facility Stamp
1						
2						
3						
4						
5						
6						
7						
8						
					Total	Total

Office Staff Only

Miles	Mode	Trips	Amount	Approval