

MEDICAL ASSISTANCE TRAVEL REIMBURSEMENT REQUEST

DATE _____

Client's name: _____

Social Security # _____

Date of Birth: _____

SECTION A.

I certify that the above named client is currently a patient at our office. The client is currently a Medical Assistance recipient. Medical services received at this facility are being supplied by an enrolled provider and are considered a compensable service for MATP purposes. He/she does not receive transportation or transportation reimbursement through any other funding sources or programs.

The client named above received medical services during the month of _____. The client attended this facility _____ times, including any additional trips for counseling / group psychotherapy sessions.

Authorized Signature

Phone Number

SECTION B.

CLIENT:

Please check dates you provided your own transportation (i.e., you did not use Bucks County Transportation, Inc.).

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

IF YOU HAVE MOVED OR CHANGED YOUR MAILING ADDRESS, PLEASE INDICATE BELOW:

MEDICAL ASSISTANCE TRAVEL REIMBURSEMENT PROCEDURE

1. Client must be registered with Bucks County Transport, Inc. Contact Bucks County Transport's Medical Assistance Coordinator at (888) 322-7522 ext. 502 if you have any questions about the registration procedure.

Requests for reimbursement cannot be considered if a valid Medical Assistance Transportation Program Eligibility Form is not on file for the dates of service.

2. All Medical Assistance Travel Reimbursement requests must be **mailed** to us. The original document must be sent in; we will not accept faxed copies and requests cannot be dropped off at our office. Medical Assistance Travel Reimbursement Requests must be received in our office by the 15th of the month to request reimbursement for the previous month. Verification for medical services must be on the medical facility's letterhead. The verification must show the patient's name and the date of service. Record the round trip mileage on the verification. A form for ongoing monthly treatment is enclosed. This form must be copied onto the facility's letterhead. The medical specialist completes section A. The client completes Section B. Do not check off days Bucks County Transport, Inc. was used as the means of transportation.
3. Submit all toll, parking or public transportation (SEPTA) receipts for the month of reimbursement along with your Medical Assistance Travel Reimbursement Request. Receipts must show the name of business, date, and the amount paid. The date must correspond with dates of treatment. No personal receipts will be acknowledged.
4. Clients residing within SEPTA zones are reimbursed at the rate of \$0.31 a mile up to the cost of a monthly SEPTA Trailpass / System Pass for their zone. Clients residing outside the SEPTA system are reimbursed \$0.31 a mile. The maximum amount clients residing outside the SEPTA system will receive for reimbursement is the highest cost of a SEPTA Trailpass / System Pass. Mileage is calculated using the shortest route.
5. Travel Reimbursement checks are mailed on or about the 25th of each month for requests received by the 15th of the month. Requests dated over 60 days from the current request month will not be honored. Please do not submit requests totaling less than \$5.00. They will not be processed.