

PIKE COUNTY TRANSPORTATION


TELEPHONE (570) 296-3408

FAX (570) 296-3409



506 BROAD STREET
MILFORD, PA 18337

INTEROFFICE MEMORANDUM

TO: MILEAGE REIMBURSEMENT CONSUMERS
FROM: CHRISTINE KERSTETTER-DIRECTOR 
RE: NEW MR FORMS

Attached please find Pike County Transportation New Mileage Reimbursement Form for your immediate use.

The new forms have been approved by the MATP Program.

Every household member must have their own form filled out completely in order for reimbursement to occur.

Please use each family members 10 digit MA Access number.

Family members that travel together on the same day will receive reimbursement for only one (1) trip.

NO reimbursement for same day trips.

AGAIN, you are responsible to mail forms only and return all forms on or before the 15th of the following month.

You are responsible for copying your "MR" forms.

Thank you.

MONTH: _____ 20_____

PIKE COUNTY TRANSPORTATION MILEAGE REIMBURSEMENT FORM

506 BROAD STREET
MILFORD, PA 18337
570-296-3408 PHONE 570-296-3409 FAX

MATP ELIGIBILITY - CIRCLE ONE - YES OR NO
PHONE NUMBER: _____
RATE: 12 CENTS PER MILE

MA ID # _____
NAME: _____
ADDRESS: _____
(Complete only if different than what is currently on file)

DATE & TIME	FAMILY MEMBER'S NAME	DESTINATION ADDRESS & ZIP	# OF MILES	\$ PARKING & TOLLS	DR./PROVIDERS NAME & PHONE #

COMPLETE AND RETURN THIS FORM WITH VERIFICATION FOR EACH ACCEPTABLE MEDICAL APPOINTMENT.
DO NOT USE THIS FORM FOR MORE THAN ONE MONTHS MEDICAL APPOINTMENT.
NO REIMBURSEMENT FOR SAME DAY APPOINTMENTS.
FAMILY MEMBERS THAT TRAVEL TOGETHER ON THE SAME DAY WILL RECEIVE REIMBURSEMENT FOR ONLY ONE (1) TRIP.
CONSUMERS ARE RESPONSIBLE TO COPY ADDITIONAL FORMS AND TO SUBMIT ALL MILEAGE REIMBURSEMENT FORMS.
CONSUMERS ARE RESPONSIBLE TO MAIL ONLY AND RETURN ALL FORMS ON OR BEFORE THE 15TH OF THE FOLLOWING MONTH.
ANY FORM POST MARKED AFTER THE 15TH OF THE FOLLOWING MONTH WILL NOT RECEIVE REIMBURSEMENT.

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 TO DOCUMENTATION OF ALL ELIGIBILITY FACTORS MAY BE REQUIRED TO DETERMINE 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.

PLEASE SIGN _____ DATE _____

Update June 2016

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VALIDATION FORM

DOCTOR / FACILITY PLEASE FILL OUT INFORMATION BELOW:

Date: _____

Patient's Name: _____

Seen by: _____

Name of Doctor/Medical Provider: _____

Address of Facility where recipient was seen today: _____

MEDICAL SERVICE PROVIDER

Your signature and stamp verifies that the patient shown on this form received an MA eligible medical service(s) in your facility on the date(s) listed.

Provider must sign a separate validation form for each individual appointment completed.

Doctor/Facility Authorized Signature Below:

NO MILEAGE REIMBURSEMENT WILL BE DISTRIBUTED WITHOUT PROPER DOCUMENTATION

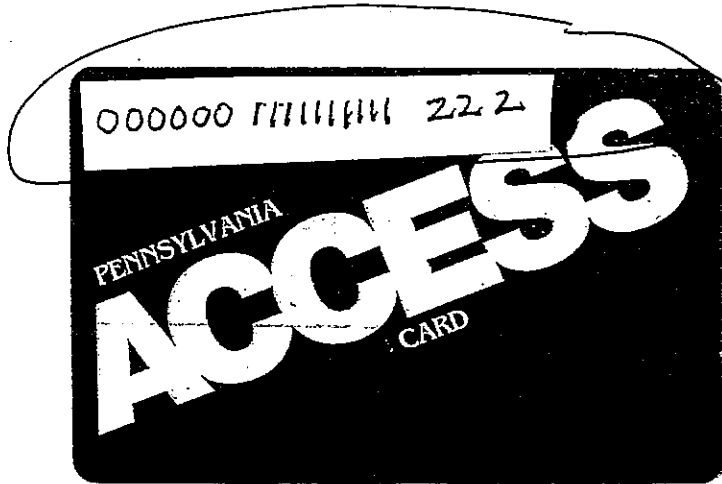
For questions please call Pike County Transportation at 570-296-3408 or 1-866-681-4947

Thank you.

Gloria Schneck

MR Coordinator

Updated 6/2016



Important!

On the new MR
Forms, please
submit entire
MA ID #.

thank you.