Lawrence County Social Services, Inc.

701 N. Mercer Street, New Castle, PA 16101 Phone: (724) 652-5588 Fax: (724) 546-5160

Lawrence County Community Action Partnership — Changing Lives

DATE RECEIVED:

Medical Recipient's Name: ____________________ **Date of Birth:** ____________________

Has your address/phone number changed? ☐ **NO** ☐ **YES** **Recipient ID Number:** ____________________

If YES: **Home Address:** ____________________ **Client Phone #:** ____________________

Address City, Zip Code

Date of Appt.	Appt. / Arrival Time	Medical Provider's **NAME** and **ADDRESS** *(Must be complete for reimbursement of trip)*	Medical Provider's **Phone Number**	Parking Fees (Receipts attached)	Road Tolls (Receipts attached)	Mileage (ONE WAY)	***MEDICAL SERVICE PROVIDERS*** *- Your signature verifies that the patient listed on 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.*
		Name: *Address:* *City, Zip:*					*Sign:* *Print name:* *MA Provider Number:*
		Name: *Address:* *City, Zip:*					*Sign:* *Print name:* *MA Provider Number:*
		Name: *Address:* *City, Zip:*					*Sign:* *Print name:* *MA Provider Number:*
		Name: *Address:* *City, Zip:*					*Sign:* *Print name:* *MA Provider Number:*
		Name: *Address:* *City, Zip:*					*Sign:* *Print name:* *MA Provider Number:*

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 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.

____________________ ____________________ ____________________

SIGNATURE of Medical Assistance Recipient (or Guardian) **PRINTED NAME of Recipient (or Guardian)** **DATE SIGNED**

************Each line MUST be filled in COMPLETELY to receive reimbursement for each trip.************

FOR OFFICE USE ONLY:

Consumer eligible on each trip date? ☐ YES ☐ NO intials __________ date__________

Mileage verified on each trip date? ☐ YES ☐ NO intials __________ date__________

Random trip verification done? ☐ YES ☐ NO intials __________ date__________ Line item verified? __________

__________ miles x .25/miles = $ ______________

$_______ Parking + $_______ Tolls = $ ___________

Total due to client = $