pennsylvania
DEPARTMENT OF HUMAN SERVICES

Mileage Reimbursement Request - Complete for Methodone Clinics Only

LAWRENCE COUNTY SOCIAL SERVICES, INC.
701 N. MERCER STREET
NEW CASTLE, PA 16101
724-652-5588 FAX 724-546-5160 TOLL FREE 1-888-252-5104

Date Received:

Medical Assistance Transportation Program

Patient				
Last Name:		First Name:		Initial:
MA Recipient #:	*OR* SSN:		Birthdate:	Phone #:

Address - Complete only if your address has changed				
Street Address:				Apartment #:
City:	Municipality:	County:	State:	Zip:

Medical Provider Address				
Provider or Practice Name:				Phone #:
Street Address:				
City:	Municipality:	County:	State:	Zip:

I hereby certify that to the best of my knowledge, the medical trip information listed on this form is true, correct, and complete. I agree to report any changes in circumstances immediately to the MATP Service Provider. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and that giving knowingly false statements is a criminal offense. I understand that 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.

Signature of Recipient, Guardian, or Head of Household _____ Date Signed _____

Mileage Reimbursement Request - Clinic

Month _____

The dates marked below are the dates which mileage reimbursement is being requested. I understand that I cannot be reimbursed for any days that I rode ACTS, was issued NCATA bus tickets or rode with any person also claiming reimbursement through MATP .

Mark the box for each date where payment is requested. Signed dosing sheet must be attached.

1	☐	7	☐	13	☐	19	☐	25	☐
2	☐	8	☐	14	☐	20	☐	26	☐
3	☐	9	☐	15	☐	21	☐	27	☐
4	☐	10	☐	16	☐	22	☐	28	☐
5	☐	11	☐	17	☐	23	☐	29	☐
6	☐	12	☐	18	☐	24	☐	30	☐
								31	☐

One Way Mileage: _____ **Parking Fees:** (Receipts Attached) _____ **Tolls Paid:** (Receipts Attached) _____

FOR OFFICE USE ONLY

Eligible on Trip Dates? ☐Yes ☐No	Verified By:	Date Verified:	Total Mileage:	X .25 =	
Mileage Verified? ☐Yes ☐No	Attendance Verified? ☐No ☐All ☐Random	Verified By:	Tolls: (Provide Receipts)		
Total Amount of Payment:	Check Number:	Payment Issue Date:	Parking: (Provide Receipts)		
			Total Reimbursement This Form:		