COMMUNITY TRANSIT

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 **.12 cents per mile**. We will also reimburse you for your actual parking expenses and tolls if you provide receipts showing how much you paid.
- Mass Transit/SEPTA Reimbursement, you will receive full reimbursement for a monthly transpass if you have 14 appointments a month or 5 appointments a week for a weekly transpass to an approved medical facility. All passes must apply to the locations of your appointments. ALL passes must be sent with the original receipt.
- All forms must be legible or will be returned.
- Consumers attending Methadone Maintenance Facilities, will only be reimbursed to the closest Methadone Maintenance Facility to their residence.
- A check will be sent to you on the 15th or the 30th of the month, along with reimbursement form for the following month. **We <u>cannot</u> reimburse beyond 60 days, the maximum reimbursement you can receive is 60 days. <u>Retroactive reimbursements will *NOT* be honored.</u>**
- If your address and/or telephone number has changed, please notify us at 610-490-3975 prior to mailing in this form.

Date Stamped by Post Office	Date Checks will go out
5th of the month	15th of the month
15th of the month	30th of the month

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

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 or on line at www.ctdelco.org.

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 **<u>your initials</u>** 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.

Office Staff Only

Mode	Trips	Mileage	Subtotal	Tolls	Parking	Total Amount	Approval
						$	

Medical Assistance Transportation Program
Reimbursement Request

To the Authorized Signer: Your signature/stamp 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 & Telephone #	SEPTA Rte #	Vehicle Mileage	Authorized Signature/ Facility Stamp
1						
2						
3						
4						
5						
6						
7						
8						
9						
			Total	Total		

Office Staff Only

Mode	Trips	Mileage	Subtotal	Tolls	Parking	Total Amount	Approval
						$	

REV. 08/27/13.