Sample ITP Service Record (Form H3017)

This is the form the ITP will fill in and mail to TMHP for payment.

Please note that you will send the form to a new address.

H3017 ITP Service Record
(unique TMTS document ID)

TMHP — Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Texas Medicaid & Healthcare Partnership
Claims
PO Box 200555
Austin, TX 78720-0555

This is where you send your completed form.

Medical Transportation Program
Individual Transportation Provider (ITP) Service Record

ITP's API and TPI NUMBER
API: ITP provider will fill out if blank
TPI: ITP MUST fill in this number - provided in welcome letter once enrollment is complete

Make sure your API and TPI are filled in.

					Middle Initial)		
CLIENT NAME (Last Name, First Name, Middle Initial) MTP will fill out this field.					**CLIENT S.I.D. NUMBER** MTP will fill out this field.		
CLIENT ADDRESS (No., Street) MTP will fill out this field.							
CITY MTP will fill out		**STATE** MTP will fill out			**Client Birth Date** MM DD YYYY MTP will fill out this	**Sex** M ☐ F☐ MTP will fill out	
ZIP CODE MTP will fill out		**CLIENT TELEPHONE** (Include Area Code) MTP will fill out this field.					

Make sure the doctor's name is filled in.

MTP AUTHORIZATION NUMBER	DATE(S) OF SERVICE MM DD YYYY	Procedure Code	Modifier Code	Place of Service			HEALTH-CARE PROVIDER NAME	HEALTH-CARE PROVIDER NUMBER	HEALTH-CARE PROVIDER SIGNATURE
MTP will fill this out	MTP will fill this out	MTP will fill this out with S0215	**TMHP will fill** this out with U1 = Self or U2 = Other	MTP wi… with 09	…with 799.9	…will fill this out	MTP or ITP will fill out	Health-care provider will fill this out	Health-care provider will fill this out

Have the doctor fill in this section.

AFFIDAVIT: This is to certify that the foregoing information is true, accurate, and complete.
I understand that payment of this claim is from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.
I hereby certify that this claim contains no willful misrepresentation or falsification and that the information I have given is true and correct to the best of my knowledge and belief. I understand that TMHP will use the information in this claim to create a CMS 1500 claim form for payment consideration.

Accept Assignment ☑ Yes

Checking the yes box indicates that you accept Medicaid's or the CSHCN Services Program's payment as payment in full.

ITP SIGNATURE ITP will sign **DATE** ITP will date

The person who drives must sign and date the form.

ITP Drivers: Please note that the allowable mileage that may be claimed for reimbursement is preprinted on the form.