CENTER FOR COMMUNITY BUILDING INC.
MEDICAL ASSISTANCE TRANSPORTATION PROGRAM (MATP)

NEW MILEAGE REIMBURSEMENT FORM NOTICE

- ALL MILEAGE REIMBURSEMENT FORMS MUST BE COMPLETED IN BLUE OR BLACK INK
- **ONLY** DOCUMENTATION ON MEDICAL PROVIDERS OFFICE LETTERHEAD WILL BE ACCEPTED
- MEDICAL DOCUMENTATION **MUST** ACCOMPANY YOUR REIMBURSEMENT SUBMISSION
- ANY FORM WITHOUT MEDICAL DOCUMENTATION **AND** PROVIDER SIGNATURE WILL BE RETURNED
- ANY FORM NOT SIGNED **AND** DATED WILL BE RETURNED

CENTER FOR COMMUNITY BUILDING INC.
MEDICAL ASSISTANCE TRANSPORTATION PROGRAM (MATP)
3525 NORTH SIXTH ST. P.O. BOX 60929 HARRISBURG, PA. 17110
MATP Number: 717-232-7009 Fax Number: 717-232-9884
1-800-309-8905 TOLL FREE NUMBER

MILEAGE REIMBURSEMENT FORM

NAME:_____
HOME ADDRESS: _____
CITY, STATE, ZIP CODE: _____TELEPHONE NUMBER: (_____)_____

(WRITTEN VERIFICATION OF MEDICAL APPOINTMENTS MUST ACCOMPANY THIS FORM)

TRIP DATE & TIME	TRIP MILEAGE (ROUNDTRIP)	DESTINATION ADDRESS & TELEPHONE #	PROVIDER SIGNATURE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

TOTAL MILES _____ X **($.12 PER MILE**) = $_____

PARKING FEE/ WITH VALIDATED RECEIPTS

DATE	EXPENSE
_____	$_____
_____	$_____

TOLLS/WITH VALIDATED RECEIPTS

DATE	EXPENSE
_____	$_____
_____	$_____

TOTAL AMOUNT REQUESTED $_____

"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 Center for Community Building, Inc. 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: _____ DATE_____

*ALL MILEAGE REIMBURSEMENT CHECKS WILL BE **MAILED** TO THE ABOVE ADDRESS WITHIN TWO WEEKS AFTER SUBMISSION OF A COMPLETED FORM.*

"Medical Service Providers - Your signature verifies that the patient shown on the front of 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."

MILEAGE REIMBURSEMENT FORM

(WRITTEN VERIFICATION OF MEDICAL APPOINTMENTS MUST ACCOMPANY THIS FORM)

TRIP DATE & TIME	TRIP MILEAGE (ROUNDTRIP)	DESTINATION ADDRESS & TELEPHONE #	PROVIDER SIGNATURE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
TOTAL MILES	_____	X **($.12 PER MILE**) = $_____	