MEDICAL ASSISTANCE TRAVEL REIMBURSEMENT PROCEDURE

Requests for reimbursement cannot be considered if a valid Medical Assistance Transportation Eligibility Form is not on file for the dates of service.

1. All Medical Assistance Travel Reimbursement requests must be mailed to us. The original document must be mailed in; we will not accept faxed copies and requests cannot be dropped off at our office.
   Verification for medical services must be on the medical facility's letterhead. The verification must show the patient's name and the date of service. A form for ongoing monthly treatment is enclosed. This form must be copied onto the facility's letterhead. The medical specialist completes Section A. The consumer completes Section B. Do not check off days Bucks County Transport, Inc. was used as the means of transportation

2. Submit all toll, parking or public transportation (SEPTA) receipts for the month of reimbursement, along with your Medical Assistance Travel Reimbursement Request. Receipts must show the name of business, date, and the amount paid. The date must correspond with dates of treatment. Personal receipts are not eligible for reimbursement. Reimbursement will be approved for trips within Bucks County or trips originating in Bucks County to Philadelphia, Montgomery, Lehigh and Northampton Counties and return.

3. Consumers are reimbursed at the rate of $0.12 a mile. Mileage is calculated using the shortest route.

4. Travel Reimbursement checks are processed twice a month. All requests for reimbursement must be received by the 15th and/or the 30th of each month.

5. Reimbursement submitted over 90 days from the date of service will not be honored. Please do not submit monthly requests totaling less than $5.00. They will not be processed. For reimbursements totaling less than $5.00 per month, please contact us for more information.

You may contact us via e-mail at Reimbursement@bctransport.org or leave a message at 215-794-5554 ext. 676. Our mailing address is:
Bucks County Transport, Inc.
P.O. Box 510
Holicong, PA 18928, Attention: Reimbursement Department.

Revised 1/16/12

MEDICAL ASSISTANCE TRAVEL REIMBURSEMENT

DATE_____

CLIENT NAME_____

M.A. ID#_____ **D.O.B.**_____

SECTION A.

I certify that the above-named client is currently a patient at our office. The client is currently a Medical Assistance recipient. Medical Services received at this facility are being supplied by an enrolled provider and are considered a compensable service for MATP purposes. He/She does not receive transportation or transportation reimbursement through any other funding sources or programs.

The client named above received medical services during the month of_____.
The client attended this facility_____ times
Spell Out Number of times (_____) including any additional trips for counseling/group psychotherapy sessions.

_____ _____
Authorized Staff Signature **Phone Number**

SECTION B.

CLIENT:

Please check dates you provided your own transportation (i.e.,you did not use Bucks County Transport, Inc.)

01_____	07_____	13_____	19_____	25_____	31_____
02_____	08_____	14_____	20_____	26_____	
03_____	09_____	15_____	21_____	27_____	
04_____	10_____	16_____	22_____	28_____	
05_____	11_____	17_____	23_____	29_____	
06_____	12_____	18_____	24_____	30_____	

IF YOU HAVE MOVED OR CHANGED YOUR MAILING ADDRESS, PLEASE INDICATE BELOW:

_____
CLIENT SIGNATURE **DATE**

I certify that the information submitted is true and correct.

Revised 12/07/16
Bucks County Transport, Inc.