

## **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 15<sup>th</sup> and/or the 30<sup>th</sup> 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 [Reimbursements@bctransport.org](mailto:Reimbursements@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.

**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 Telephone \_\_\_\_\_

\_\_\_\_\_  
Please Print Staff Name

**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.