MATP Reimbursement Form

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 $0.12 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 for a weekly TransPass if you have 5 appointments a week, 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 and COMPLETE or they 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 between the 25th and 28th of the month for trips made the previous month, along with a reimbursement form. We cannot reimburse beyond 60 days; the maximum reimbursement period is 60 days.
- Retroactive reimbursements will NOT be honored.
- If your address and/or telephone number has changed, please notify us at 610-490-3975 prior to mailing in this form.
- NO DROP-OFF OR FAXES WILL BE ACCEPTED.

MUST BE POSTMARKED BY THE 15th OF EVERY MONTH. Mail to:
DELGO Community Transit – MATP
2001 Industrial Highway
Eddystone, PA 19022

Consumer name: _____

Consumer ID #: _____

Address (only if different from what is on file): _____

Facility attending: _____

Please complete the other side of this form if you travel to more than one medical facility or pharmacy. If additional forms are needed, make copies or go online at www.ctdelco.org.

SEPTA route: _____

OR

Miles driven per day (round trip): _____

Month requesting reimbursement (1 month per form): _____

Dates attended facility. Indicate which days you attended the above medical facility for the month by placing your initials 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 eligible date is the date on which the reimbursement was authorized.

Please follow proper procedures so your reimbursement is not delayed. There are no exceptions. Remit ALL ORIGINAL receipts and signatures. Be as specific as possible. NO FAXES ACCEPTED. SIGN THE BACK OF THIS FORM.

Office use only

PJ#	Mode	Trips	Mileage	Subtotal	Tolls	Parking	Total	Approval

To the Authorized Signer: Your signature/stamp on this form indicates that this client has received Medical Assistance-reimbursable services from you at your facility, that you signed the form on the date indicated, and that they presented a current ACCESS card to you.

Please print clearly.

Visit	Date	Facility address & telephone #	SEPTA Rte #	Vehicle mileage	Authorized signature / facility stamp
1					
2					
3					
4					
5					
6					
7					
8					
9					

“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 MATP Service Provider. 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.”

Consumer signature: _____

Date: _____