MATP MILEAGE REIMBURSEMENT FORM

DATE REQUESTED: ___________________
DATE OF APPT: ______________________

ENDING ODOMETER: _________________
BEGINNING ODOMETER: ______________
TOTAL MILEAGE: ____________________

CLIENT NAME: ______________
MA ID #: ______________________
ADDRESS: ___________________ (only needs filled out
_______________________________ if you are new or have
relocated)
PHONE: ______________________
PARENT NAME: ______________

In order to provide mileage reimbursement for out of county trips, you must:

1. Be unable to receive this medical service locally.
2. Have a signed paper from your local doctor stating this service is not available in the county.
3. Call each appointment in to the C.A.R.S. office **BEFORE** you go to your appt.
4. Upon return, have a signed form from the doctor verifying you received medical treatment from the signed doctor on the date and time of appt.
5. Must have a valid driver's license, current registration and insurance. If someone is driving you, we will need the information of that individual.

We cannot provide reimbursement for prior, unauthorized trips.
You must provide beginning and ending odometer readings.
The driver must provide a valid driver's license, current registration and insurance.
You must fill out a separate form for each appointment.
This form must be completed, signed and returned to our office before reimbursement can be made.
***Payments will be made to the client or the parent or legal guardian of a client.
If you as the client are paying someone to take you to the doctor, it is up to you to make sure that the individual is reimbursed.
***Mileage Reimbursements are processed bi-weekly. Payments are received every other Wednesday. Please ask the staff person processing your reimbursement when you may expect a check. Payment schedule attached.
***A request for mileage reimbursement will not be accepted after a 60 day period following your doctor's appointment.
***We use Map Quest to confirm mileage.
***MATP reimburses for mileage from your home, directly to your eligible medical appt., then a direct return to your home.
***All mileage requests must be processed through this office. However; we will refer all overnight stays, appointments beyond our service area, and out of state appointments to the local CAO (County Assistance Office).
***You will receive $.12 per mile.
***If you carpool with another client, only one of you will be paid reimbursement.

"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.

I have read and understand the rules and by signing I agree: ________________________Date: ____________

PLEASE NOTE: Suspicion of fraud will be reported to the Office Inspector General's office for investigation. Any misuse of funds provided to this service is unacceptable.