Washington County Transportation Authority
50 E. Chestnut Street
Washington, PA 15301
1-800-331-5058 (toll free)
724-223-8747 (phone)

REIMBURSEMENT REQUEST FORM

STAMPS, COPIES, OR FAXES OF A SIGNATURE WILL NOT BE ACCEPTED, ONLY APPROVED ORIGINAL SIGNATURES ARE ACCEPTED

FOR (Patient): _____ PAYABLE TO (Patient/Guardian):_____

PATIENT NUMBER (MA ID #): _____ SUBMISSION DATE: _____

"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.

PATIENT/GUARDIAN SIGNATURE: _____

DO YOU HAVE A PERMANENT OR TEMPORARY CHANGE IN ADDRESS, EITHER PHYSICAL OR MAILING?
YES ☐ NO ☐
PLEASE INDICATE TYPE OF CHANGE: PHYSICAL ☐ MAILING ☐
NEW P.O. BOX #: _____ NEW ADDRESS: _____
CITY: _____ ST: _____ ZIP: _____

TO BE COMPLETED BY MEDICAL PROVIDER
PROVIDER INFORMATION: (*PLEASE FILL OUT COMPLETELY)*
PROVIDER/PRACTICE NAME: _____ TELEPHONE #: _____
ADDRESS: _____ CITY: _____ ST: ___ ZIP: _____
APPOINTMENT DATE: _____ APPOINTMENT TIME: _____
"Medical Service Providers - Your signature verifies that the patient shown on this form received an MA eligible medical service(s) in your facility on the date(s) listed. You must sign to verify each appointment."

PROVIDER SIGNATURE: _____

PARKING (IF ANY): _____ TOLLS (IF ANY): _____ TRIP MILEAGE: _____
***RECEIPT MUST BE ATTACHED TO PROCESS ANY REQUESTS FOR PARKING/TOLL FEES**

The following rules apply to the MATP Mileage Reimbursement Program

►All information must be completed on this form; only COMPLETED forms with **original signatures** will be processed.
Photocopies, Stamps, or faxed signatures will NOT be accepted.
►Forms must be received within 45 calendar days of the date of service.

If client reimbursement is made based upon falsified information, WCTA may require the following:

►Customer will be responsible for repayment in full to WCTA.
►Customer will have amount in question deducted from future reimbursements.
►Client will be ineligible for further services from WCTA.

INTERNAL USE ONLY

ELIGIBLE ON TRIP DATE: YES ☐ NO ☐ VERIFIED BY: _____DATE: _____

MILEAGE VERIFIED: YES ☐ NO ☐ TRIPS LOGGED INTO SOFTWARE: YES ☐ NO ☐

ATTENDANCE VERIFIED THROUGH MATP GRANTEE CONTACT WITH PROVIDER: YES ☐ NO ☐

ATTENDANCE VERIFIED BY: _____ DATE: _____

DATE RECEIVED: _____ WITHIN 45 DAYS: YES ☐ NO ☐

TOTAL MILEAGE: _____ TOLLS: _____
x.12 = CHECK AMOUNT: _____ PARKING: _____
TOTAL PAYMENT DUE: _____

PAYMENT ISSUE/REQUEST DATE: _____ CHECK NUMBER (IF KNOWN):_____

_____ **DATE: _____**
APPROVED FOR PAYMENT

SPECIAL NOTES: _____

_____

_____

_____