

# Mileage Form Guidelines

- ◆ **If you are no longer able to use mileage, we must have in writing the reasons why and proof of the situation. Please call with any questions about determination of services.**
- ◆ Mileage forms must be received in our office by the 3<sup>rd</sup> of each month. If you miss a deadline your reimbursement will be held and processed with the next cycle. Any trips later than 60 days will be denied
- ◆ Mileage limits are set by DHS and is currently \$0.25 per mile.
- ◆ Please use one form per person.
- ◆ Do not fax this form. All signatures must be originals or they are not valid trips.
- ◆ If there are multiple people using the same vehicle, any trips to the same location can only be paid once. Mileage is per trip not per person.
- ◆ Have the actual form signed by provider. Occasionally slips can be accepted for extenuating circumstances, but not as a regular replacement for signatures.
- ◆ Receipts for tolls and parking must include all information on location of parking and be a valid receipt (not hand written).
- ◆ Please paperclip attachments. Don't staple, tape or glue papers to the original form. Please label each attachment with the name of the client as papers can get separated.
- ◆ Fill in all information including miles traveled and the name and phone number of the location. If any of this information is missing it could result in the return of the form or cause the trip to be invalid.
- ◆ All signatures need to be in pen.
- ◆ Only use mileage sheets for one calendar month from the 1<sup>st</sup> until the end of that month.
- ◆ If the address of the payee is different from client, always include a contact number for the payee.
- ◆ If you are in need of more forms, please call us. Only make copies if you can submit the copies in the two sided format we use. The reverse side is required for use in the office.
- ◆ **Methadone Consumers**  
Effective March 1, 2012, the Department of Human Services has limits on the distance consumers may be reimbursed for driving themselves to methadone maintenance treatment.
  - ◆ You may only be reimbursed to the clinic, in your Behavioral Health Managed Care Plan's (BH-MCO) network, that is closest to your home. We have worked with your BH-MCO to decide the closest network clinic that you could attend.
  - ◆ If you would like information about receiving treatment at a clinic that is closer to you please contact *County Behavioral Health Plan* at 866-542-0299.
  - ◆ If you think you will be submitting a mileage claim for reimbursement, please contact Rabbittransit at 1-800-632-9063 to discuss your options.

**MILEAGE for Medical Assistance Transportation Program**

Total Miles	Time	Date of Appointment	Medical Location and Address	Person Treated (One person per sheet)	Provider Signature** and Phone # (Lack of signatures for each trip will make trip invalid)

**\*\*AS A PROVIDER**, your signature verifies the client was there and you are ACCEPTING MEDICAL ASSISTANCE AS PAYMENT FOR THE SERVICES.

**By signing this document, I do hereby verify that the facts set forth in the above mentioned application are true and correct to the best of my personal knowledge or information and belief, and that any false statements herein are made subject to the penalties of:**  
PENNSYLVANIA CRIMES CODE TITLE 18 SECTIONS: (4903 FALSE SWEARING), (4904 UNSWORN FALSIFICATION) and (4911. TAMPERING WITH PUBLIC RECORDS OR INFORMATION)  
VIOLATIONS OF THESE SECTIONS ARE SUBJECTED TO PUNISHMENT OF A FINE NOT EXCEEDING \$5000.00. OR TO A TERM OF IMPRISONMENT OF NOT MORE THAN (TWO) (2) YEARS. OR BOTH.

I give permission for any medical provider listed on this form to release information related to my attendance to the said provider for medical treatment and the method/means of how the treatment was paid.

SIGNATURE OF CLIENT \_\_\_\_\_ 10 Digit Recipient # \_\_\_\_\_ Date \_\_\_\_\_  
 PRINT NAME OF CLIENT \_\_\_\_\_ Phone # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Print Guardian or Payee's Name \_\_\_\_\_ Address: \_\_\_\_\_



**VERIFICATION FOR M.A.T.P**

You are required to verify all medical appointments. Please return this form to the address below by the 3<sup>rd</sup> of each month before 5pm. **Specific trip dates older than 60 days will not be processed.** Dates older than this time will be invalid and will not be reimbursed.

If you have any questions, please contact 846-RIDE (7433) or 1-800-632-9063 and speak to a staff member. Use the reverse side to record all trip information. This agency reserves the right to verify the signatures of providers on this document. We also reserve the right to verify the mileage.

**IMPORTANT: The end of rabbittransit's fiscal year is on June 30 of each year. In response to this, all forms must be received in our office by July 5, keeping in mind that only dates 60 days prior to submission can be reimbursed. Again, if they are received after July 5, they will not be processed because we can not carry billing across fiscal years.**

Please return to:  
ATTN: Mobility Planning  
rabbittransit  
415 Zarfoss Dr.  
York, PA 17404

**Remember to SIGN this form; failure to do so, will delay reimbursement.**

In order for a guardian/care taker to receive a reimbursement check, please provide the guardian's information in the appropriate area on the reverse side.

**FOR OFFICE USE ONLY**

	<u>TRIPS</u>	<u>MILES</u>	<u>AMOUNT</u>
M.A.T.P.	_____	_____	_____
Total Trips Authorized	_____	Mileage _____	Total amount reimbursed \$ _____
Office personnel signature	_____		Date: _____