

Non-Emergency Medical Transportation Claim Form



Client MA# _____ Name: _____ Address: _____ _____ Check payable to: _____ Address: _____ Phone: _____ Signature required on page 2 Relationship to MA Recipient (<i>please circle one</i>) Self Foster Care Provider Parent/Guardian Volunteer PCA Friend/Neighbor/Relative	<p><i>Mail completed form no later than 90 days from date of appointment to:</i></p> <p>Wright County Human Services Medical Transportation Service 1004 Commercial Dr Buffalo, MN 55313 - 1736</p> <p>Phone: 763-682-7482 Note: <u>You must call Wright County in advance to get prior approval for meals & lodging if staying overnight.</u></p>
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Appointment Date	Departure Address (If this is your home address write HOME)	Attach parking and meal receipts. List Total Here	Name, Address and Phone Number of Health Care Provider you saw	Odometer Start	Odometer End	Total Trip Miles	I certify that this patient was seen for a MA covered health service. Required Signature & Title of Health Care Provider

See back side of form for expense totals.

You must complete each column above for each trip. If you are eligible we will send a check for the trips that are documented and approved. If we do not have complete information, we will send the form back to you. Only submit meal expenses for yourself or if an adult with a child receiving medical treatment, you may submit for one adult along with the child. Questions? Call 763-682-7482

Over

Appointment Date	Departure Address (If this is your home address write HOME)	Attach parking and meal receipts. List Total Here	Name, Address and Phone Number of Health Care Provider you saw	Odometer Start	Odometer End	Total Trip Miles	I certify that this patient was seen for a MA covered health service. Required Signature & Title of Health Care Provider

I declare under the penalties of perjury that this account, claim, or demand is just and correct and that no part of this claim has been previously paid. The effect of this verification shall be the same as if subscribed and sworn to under oath.

Note: rate was \$.19 1/1/11-2/28/11; \$.20 on 3/1/11

(Signature by driver)

Date

Please check those that apply:

If traveling greater than thirty-five (35) miles from home, I request reimbursement for the following:

Breakfast – Patient is required to travel before 6:00 a.m. for medical appointment

Lunch – Patient’s scheduled morning appointment extended beyond 1:00 p.m.

Supper – Patient returned home after 7:00 p.m. directly from medical appointment

Meal receipts must be attached. County must have Letter of Medical Necessity on record.

Issuance Date _____

Warrant # _____

Approval _____

Date _____

Claim Totals

Mileage: \$0.20 x ____ miles = \$ _____

\$0.51 x ____ miles = \$ _____

(Foster Care and WC Volunteers Only)

Parking: \$ _____

Lodging: \$ _____

Meals: \$ _____

Total Claim: \$ _____