NEW YORK STATE | Department of Health | Office of Health Insurance Programs

Physician Attestation for Mileage Reimbursement Individual Appointments

Mail Claims to: Volunteer Transportation Center
203 N. Hamilton Street
Watertown, NY 13601

Invoice #:	
Date of Appointment:	
County of Medicaid:	

Medicaid Enrollee:

Medicaid #:
Name:
Physical Address:
Mailing Address:
City/State/Zip:
Phone:
SSN:
Change in address?

Driver Information (If not Enrollee):

Name:
Relation to Enrollee:
Physical Address:
Mailing Address:
City/State/Zip:
Phone:
Driver's License Number & State: (attach a copy of the license)
License Plate Number & State:

Medical Provider: In signing, the Physician certifies that the Enrollee was treated at this office location on this date.

Date of Visit:	**Providers Name:**	**Providers Address:**	**Providers Phone:**	**Provider's Signature:**

Travel Expense:

Tolls:	Food:	Ferry:	**Total:**
Parking:	Hotel:		

Enrollee/Driver:
As a driver for the Medicaid Enrollee, I certify that I provided transportation for the above listed appointment on the date indicated. I am claiming reimbursement for such travel. I understand that in signing below, I am claiming that the above information, including addresses, are true. False statements may result in the referral to the Office of Medicaid Inspector General for investigation of Medicaid fraud.

Medicaid Enrollee Signature: _____ Date: __/__/____

Driver Signature: _____ Date: __/__/____