

www.VolunteerTransportationCenter.org



Phone (315) 788-0422 Fax (315) 788-8021

Step-by-Step Guide to Self Drive Reimbursement

1. Request a reimbursement form from the VTC. We can mail, email or fax you a form. You can even go our website and download your own form.
2. Call MAS to request an invoice number.
3. Complete the form and return it to the VTC within 30 days of the trip. All forms received by every other Thursday will be reimbursed the following Friday. Forms may be returned to:

By mail: Volunteer Transportation Center
24685 Route 37 Watertown, NY 13601

By Fax: (315) 788-8021

By Email: reimbursement@volunteertransportation.org

4. If you would like to have your reimbursement direct deposited into your bank account, please complete and return the enclosed form.

Questions? Call Honey Marie at (315) 788-0422 x2908.

Physician Attestation for Mileage Reimbursement Individual Appointments

Mail Claims to: Volunteer Transportation Center
 24685 Route 37
 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: __/__/__



Mileage Reimbursement

Mail Claims to:

Volunteer Transportation Center, Inc.
24685 Route 37
Watertown, NY 13601

Multiple Appointments

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: (Required for Payment)
License Plate Number:

Invoice #	Date:	Provider Name:	Provider Address:	Provider Phone:	Provider Signature:

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: __/__/____

ACH CREDIT AUTHORIZATION

(To Single Account)

I (we) hereby authorize Volunteer Transportation Center, Inc., hereinafter called COMPANY, to initiate credit entries to my (our) account indicated below and the financial institution below, hereinafter called FINANCIAL INSTITUTION, to credit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

(Financial Institution Name)

(Branch)

(Address)

(City/State)

(Zip)

(Routing Number)

(Account Number)

Type of Account (check one):

_____ Checking _____

_____ Savings

This authority is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and manner as to afford COMPANY and FINANCIAL INSTITUTION a reasonable opportunity to act on it.

(Print Individual Name)

(Signature)

(Date)

PLEASE ATTACH COPY OF VOIDED CHECK TO THIS FORM