Mileage Reimbursement

Multiple Appointments

Mail Claims to:

MEDICAL ANSWERING SERVICES, LLC
P O BOX 12000
SYRACUSE, NY 13218

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:
SSN: (Required for Payment)
Change in Address?

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: __/__/____