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

# Physician Attestation for Mileage Reimbursement Individual Appointments

**Mail Claims to**: Medical Answering Svcs, LLC
P O Box 12000
Syracuse, NY 13218

| | |
|---|---|
| **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: |
| SSN:<br>(Required for Payment) |
| Change in Address? |

**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: __/__/____