MATP
Invoice: Volunteer Transportation Services

Last Name ______ **First Name** ______ **MI** ______

Receipient No. ______ **Birthday** ______ **Group #** ______

Address ______ **APT #** ______ **Phone** ______

City ______ **Zip Code** ______ **SSN** ______

Number of One-Way Trips ______ **Rate Per Mile** ______

Mileage per One-Way ______ **Invoice Amt:** ______

If service was not provided by client, list below the provider.

Name: ______

Address: ______

Phone: ______

Signature of client: ______ **Date:** ______

Signature of Transportation Provider: ______ **Date:** ______

**** THIS PORTION MUST BE COMPLETED BY THE MEDICAL SERVICE PROVIDER****

The above named client is eligible for transportation services for medical purposed through the Medical Assistance Transporation Program. The Beaver County Transit Authority, as the administrator of the Medical Assistance program in Beaver County, must ensure that the client is being reimbursed for an eligible trip. In order to verify the clients' trip to your office/facility, BCTA is asking that the medical provider sign and date this form below.

If you have any questions relating to this program, please contact the BCTA office. The addesss is 200 W. Washington Street, Rochester, PA 15074. Telephone: (724) 728-5633 or 1-800-262-0343.

Signature of Service Provider: ______

Date and appt. time client received service: ______

Address and phone of performing facility: ______