Fixed Route Reimbursement Form

Section 1-Applicant Information

Print Last Name		Print First Name	
Street Address		City, State	
Zip Code	Phone	Date of Birth	Recipient Number

Section 2 – Qualifying Trip Information

Date	Appt. Time	Bus Route	Fare Paid	Name and Address of Medical Facility	Signature (or Stamp) of Medical Provider

****AS A PROVIDER,** your signature verifies the client was there and you are ACCEPTING MEDICAL ASSISTANCE AS PAYMENT FOR THE SERVICES.

By signing this document, I do hereby verify that the facts set forth in the above mentioned application are true and correct to the best of my personal knowledge or information and belief, and that any false statements herein are made subject to the penalties of:

PENNSYLVANIA CRIMES CODE TITLE 18 SECTIONS: (4903 FALSE SWEARING), (4904 UNSWORN FALSIFICATION) and (4911, TAMPERING WITH PUBLIC RECORDS OR INFORMATION) VIOLATIONS OF THESE SECTIONS ARE SUBJECTED TO PUNISHMENT OF A FINE NOT EXCEEDING $5000.00, OR TO A TERM OF IMPRISONMENT OF NOT MORE THAN (TWO) (2) YEARS, OR BOTH.

I give permission for any medical provider listed on this form to release information related to my attendance to the said provider for medical treatment and the method/means of how the treatment was paid.

Signature of client/or parent-guardian Date:

Interoffice Use Only:

Verification

Total Trips: _____

Total Amount Paid: _____

Date: _____

Staff Signature: _____

Remit to: rabbittransit
415 N Zarfoss Dr., York, PA 17404
(Phone) 717-846-7433 (Fax) 717-848-4853