**KILOMETRAJE DE Medical Assistance Transportation Program**

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| --- | --- | --- | --- | --- | --- |
| **Total de Millas** | **Hora de la cita** | **Fecha de nombramiento** | **UBICACIÓN MÉDICA Y DIRECCIÓN** | **Persona Tratada**  **(Una persona por hoja)** | **Firma del Proveedor\*\* y telefono #**  **(Lack of signatures for each trip will make trip invalid)** |
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**\*\*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.**

**FIRMA DEL CLIENTE­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10 Digit Recipient #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ESCRIBE EL NOMBRE DEL CLIENTE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telefono #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fecha de Nacimento\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­**

**Escriba el nombre del tutor o del beneficiario\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Habla a\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**