



**Regional Transportation Program, Inc
Out of State Reimbursement Forms
Mileage, Tolls and Parking**

Patient's Name _____ Patient's Medicaid Number _____

Expenses For (Driver's Name) _____ Relationship to Patient _____

Driver's Address _____
Street City State Zip

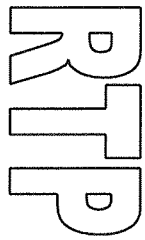
Expenses For _____ And
 The Week Beginning _____ Ending _____

A	B	C	Mileage			G	H
			D	E	F		
Date	Origin	Destination	Start Odometer	End Odometer	Total (E - D = F)	Tolls	Parking
Totals							

Client must be eligible for MaineCare on the dates of the appointments listed above. MaineCare eligibility is confirmed by RTP before any reimbursement is made.

I, _____, do hereby affirm that I am legally eligible for reimbursement for the expenses requested under all applicable laws, rules and regulations; that all documents submitted, including all attachments and enclosures, are a true, accurate and complete representation of the above-required documentation; and that I understand that this request is for reimbursement under the MaineCare Program as administered by the Maine Bureau of Medical Services and RTP has no obligation beyond such reimbursement.

Printed Name _____ Signature _____ Date _____



**Regional Transportation Program, Inc
Out of State Reimbursement Forms
Overnight Expenses**

Patient's Name: _____ Patient's Medicaid Number: _____

Expenses For: _____ Relationship to Patient: _____

Address: _____

Street _____ City _____ State _____ Zip _____

Day	Date mm/dd/yyyy	Breakfast** Limit \$6.00	Lunch** Limit \$8.00	Dinner** Limit \$16.00	Room Max \$65 / Night	Public Transit	Other Ground Transportation**	Total Daily Cost
Sunday								
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
Saturday								
Total Weekly Cost								

** For these expenses (meals, room, and ground transportation) you are required to submit clearly understandable, original receipts issued by those vendors from whom you purchased the goods or services. Each receipt must be dated, and you must clearly note on the back of the receipt what was purchased (ie lunch 3/2/99). No reimbursement will be made for any expense which is not supported by the above documentation of if the documentation submitted is confusing, incomplete, inaccurate, altered, or RTP otherwise finds that the documentation submitted does not fully support the requested reimbursement for any reason.

The first request for reimbursement submitted each month **MUST INCLUDE A COPY OF THE MEDICAID ELIGIBILITY CARD** for that month. **NO** reimbursement will be made unless and until this monthly copy of your eligibility card is submitted.

I, _____, do hereby affirm that I am legally eligible for reimbursement for the expenses requested under all applicable laws, rules and regulations; that all documents submitted, including all attachments and enclosures, are a true, accurate and complete representation of the above-requested documentation; and that I understand that this request is for reimbursement under the Maine Medicaid Program as administered by the Maine Bureau of Medical Services and RTP has no obligation beyond such reimbursement.

Printed Name _____ Signature _____ Date _____