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

Physician Attestation for Bus Pass 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?

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:

Bus:			Total:

Enrollee:

As a Medicaid Enrollee, I certify that I paid for 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: ____/____/____