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

Bus Pass Reimbursement

Mail Claims to:

MEDICAL ANSWERING SERVICES, LLC
P O BOX 12000
SYRACUSE, NY 13218

Multiple Appointments

County of Medicaid	

Medicaid Enrollee:

Medicaid #:
Name:
Physical Address:
Mailing Address:
City/State/Zip:
Phone:
SSN:
Change in address?

Invoice #	Date:	Provider Name:	Provider Address:	Provider Phone:	Provider Signature:

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: __/__/____

Driver Signature: _____Date: __/__/____