



Fulton County Partnership, Inc.  
Medical Assistance Transportation Program  
PO BOX 464, McConnellsburg, PA 17233  
717-485-0931 or 888-329-2376 toll free  
info@fcpinc.net / www.fcpinc.net / Fax 717-485-4505

**Directions:**

1. This form is to be used solely for the purpose of requesting reimbursement for transportation expenses to and from a source of necessary medical care. **HAVE THE FORM SIGNED** by your doctor or another authorized individual within the medical facility in order to verify that you received treatment on the date listed. **The MEDICAL ASSISTANCE PROVIDER NUMBER MUST ALSO BE WRITTEN IN THE SAME BLOCK AS THE SIGNATURE.**
2. Payment will be made at the rate of \$0.20 per mile. Special cases with frequent long distance trips will be referred to the County Assistance Office for reimbursement. No reimbursement will be made for trips outside the service delivery area.
3. Your request for reimbursement (this form) must be sent to the Fulton County Partnership, Inc. at the address listed above in order for checks to be processed. **YOU ARE RESPONSIBLE FOR SUBMITTING COMPLETED FORMS.** Incomplete forms will be returned unprocessed.
4. You will only be reimbursed for one trip to the same town per day. You will only be reimbursed for two trips to the pharmacy per week. When possible, trips for family members must be consolidated.
5. Please be sure to complete **ALL** information requested on this form and return it to our office as promptly as possible so that we may better serve you
6. You will not be compensated for trips that occurred more than 15 days prior to the submission of this form. If you have any questions, please call the number listed above, and ask for the MATP coordinator.

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I have made the trips listed on the back of this form solely for medical attention. I understand that requesting false medical transportation is subject to repayment and possible legal action taken by the Commonwealth of Pennsylvania.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Client Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Client's Address: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Total Miles: \_\_\_\_\_ X \$0.20 = \$ \_\_\_\_\_

Payment made to: \_\_\_\_\_

In the amount of: \$ \_\_\_\_\_ on \_\_\_\_\_

Comments: \_\_\_\_\_

