

## ITP Service Record (Claim Form)

<b>Client Name:</b>	<b>Client Telephone:</b> (     )	<b>Client Medicaid:</b>
<b>ITP Name:</b>	<b>ITP Telephone:</b> (     )	<b>ITP MTI Number:</b>

<b>Trip #1</b>			
<b>From:</b>	<b>To:</b>	<b>Miles:</b>	<b>Amount:</b>
<b>From:</b>	<b>To:</b>	<b>Miles:</b>	<b>Amount:</b>
<b>Authorization Number:</b>	<b>Appointment Date/Time:</b>	<b>Total Miles:</b>	<b>Total Amount:</b>
<b>Health Care Provider NPI:</b>	<b>Health Care Provider Telephone:</b> (     )	<b>Health Care Provider Name:</b>	
<b>I certify that this patient was seen for a Medicaid/CSHCN covered health-care service.</b>	<b>Signature &amp; Title of Health-care Provider:</b>		<b>Date Signed:</b>

<b>Trip #2</b>			
<b>From:</b>	<b>To:</b>	<b>Miles:</b>	<b>Amount:</b>
<b>From:</b>	<b>To:</b>	<b>Miles:</b>	<b>Amount:</b>
<b>Authorization Number:</b>	<b>Appointment Date/Time:</b>	<b>Total Miles:</b>	<b>Total Amount:</b>
<b>Health Care Provider NPI:</b>	<b>Health Care Provider Telephone:</b> (     )	<b>Health Care Provider Name:</b>	
<b>I certify that this patient was seen for a Medicaid/CSHCN covered health-care service.</b>	<b>Signature &amp; Title of Health-care Provider:</b>		<b>Date Signed:</b>

*ITP Drivers: Please note that the allowable mileage that may be claimed for reimbursement is preprinted on the form.*

**AFFIDAVIT:** This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim is from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws. I hereby certify that this claim contains no willful misrepresentation or falsification and that the information I have given is true and correct to the best of my knowledge and belief. **I attest that I have complied with all of the provisions of the Individual Transportation Participant Agreement when providing the transportation services for which I am seeking reimbursement.**

\_\_\_\_\_  
Signature of Individual Transportation Participant (ITP)

\_\_\_\_\_  
Date

**All forms must be mailed to Logisticare**  
 ATTN: Compliance  
 12234 N. I -35, Suite 175  
 Austin, TX 78753  
**Note:** Please retain a copy for your records