Access2Care
A Global Medical Response Solution

ITP Service Record (Trip Log/Claim Reimbursement Form 3103)

Client Name:	Client Telephone: ( )	Client Medicaid:
ITP Name:	ITP Telephone: ( )	ITP Driver's License #

Trip #1

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

Trip #2

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

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 sent to
A2C ATTN: ITP CLAIMS
9555 W Sam Houston Pkwy S, Suite 500
Houston, Texas 77099
Fax: 713-747-9453
Email: claimsdept@gmr.net
Note: *Please retain a copy for your records*