

SafeRide Health

ITP Service Record-Molina Health Plan (Claim Form)

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|---------------------|--------------------------|----------------------------|
| Client Name: | Client Telephone: | Client Medicaid ID: |
| | () | |
| ITP Name: | ITP Telephone: | ITP MTI Number: |
| | () | |

| | | | | |
|---|------------------------|---|-----------------------------------|----------------------|
| Trip #1 | | | | |
| From: | | To: | Miles: | Amount: |
| | | | | |
| From: | | To: | Miles: | Amount: |
| | | | | |
| Ride ID (A-leg) | Ride ID (B-leg) | 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: |
| | | | | |
| Ride ID (A-leg) | Ride ID (B-leg) | 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 claim forms must be sent via email, mail, or fax to:
 email: molina_claims@saferridehealth.com
 fax: 1-888-453-5398
 mail: 18302 Talavera Ridge Ste. 300
 San Antonio, TX 78257