

SafeRide Health

ITP Service Record-Texas Children's Health Plan (Claim Form)

Client Name:	Client Telephone:	Client Medicaid ID:	
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ITP Name:	ITP Telephone:	ITP MTI Number:	
	()		
Trip #1			
From:	To:	Miles:	Amount:
From:	To:	Miles:	Amount:
Authorization Number/Ride ID:	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/Ride ID:	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, fax, or mail to:
email: texaschildrens_claims@saferridehealth.com fax:
1-888-453-5398
mail: 18302 Talavera Ridge Ste 300
San Antonio, TX 78257