# ITP Service Record

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Client Telephone:</th>
<th>Client Medicaid:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>ITP Name:</th>
<th>ITP Telephone:</th>
<th>ITP MTI Number:</th>
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**Trip #1**

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
<th>Miles:</th>
<th>Amount:</th>
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Authorization Number: Appointment Date/Time: Total Miles: Total Amount:

<table>
<thead>
<tr>
<th>Health Care Provider NPI:</th>
<th>Health Care Provider Telephone:</th>
<th>Health Care Provider Name:</th>
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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**

<table>
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<th>To:</th>
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I certify that this patient was seen for a Medicaid/CSHCN covered health-care service.

Signature & Title of Health-care Provider: Date Signed:

**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

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All Service Records/Claim forms must be sent to Project Amistad  
3210 Dyer St., El Paso, TX 79930  
FAX: 915-626-5422  
Email: itpfinance@projectamistad.org  

Note: Please retain a copy for your records