

**Mark Feinman**  
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Bucks County Office  
49 Cropwell Lane  
Holland, PA 18966  
(215) 504-9626

July 2, 2012

COMMONWEALTH OF PENNSYLVANIA  
Pennsylvania Public Utility Commission  
PO Box 3265  
Harrisburg, PA 17105-3265  
ATTN: LISA MILLETICS, COMPLIANCE SPECIALIST

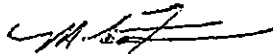
RE: **Healthcare Transportation Service, LLC**  
No.: A-2011-2266758

Dear Ms. Milletics:

Pursuant to your June 5, 2012 correspondence, enclosed herein please find the Verified Statements in Support of the Application relative to the above-captioned matter.

Thank you for your prompt attention to this matter.

Very truly yours,



MARK FEINMAN

MF/gmr  
Enclosures

**FEDERAL EXPRESS - PRIORITY OVERNIGHT #8713-1120-1701**

RECEIVED

2012 JUL -9 AM 8:

SECRETARY'S BUREAU

RECEIVED  
BUREAU OF  
TECHNICAL UTILITY SERVICES  
2012 JUL -3 PM 2:02

Jun 13 12:01:41p

Cigarette & Cigar II, Inc

215-722-3556

REC'D  
2012 JUN -9 AM 11:17  
SECRETARY'S OFFICE  
p.5

**VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION**

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

RICHARD MARCOT.  
Name of Supporter

520 N. DELAWARE AVE. PHILADELPHIA CO, PHILADELPHIA, PA 19123  
Street Address City or Municipality County State Zip Code

HEALTH CARE TRANSPORTATION SERVICES LLC  
Name of Applicant

- Describe the type of transportation service needed. *TRANSPORTATION FOR MEDICARE & MEDICARE MEMBERS.*
- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships. *PHILADELPHIA COUNTY & SURROUNDING COUNTIES.*
- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?  
*THERE ARE PRESENTLY 450,000 PLUS MEDICARE MEMBERS IN PHILADELPHIA COUNTY USING THIS SERVICE DAILY, WEEKLY & MONTHLY*
- Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?  
*THERE ARE OTHER COMPANIES BUT COMPATIBILITY IS A GOOD THING FOR SERVICE & PRICING.*
- Have you supported similar applications in the past? If so, please supply name and docket number.  
*NO.*

RECEIVED BUREAU OF TECHNICAL UTILITY SERVICES  
2012 JUL 3 PM 2:02

**VERIFICATION OF STATEMENT**

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to sworn falsification to authorities.

*Richard Marcot*  
(Signature) Richard L. Marcot  
(Name, printed or typed)

6/25/12  
(Date)

**VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION**

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

IBRAHIM MOHAMED, MFT      215-305-2705  
Name of Supporter

2115 Friendship Street      Philadelphia, PA      19149  
Street Address      City or Municipality      County      State      Zip Code

Ibrahim I. mohmed Healthcare  
Name of Applicant      TRANSPORTATION SERVICE, LLC

- Describe the type of transportation service needed.

WHEEL CHAIR AND AMBLATORY FROM CLIENT'S HOMES TO COMHAR FACILITY

- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.

FROM CLIENT'S HOMES TO COMHAR'S FACILITY at 3825 Whitaker Ave, Philadelphia, PA, 19124.

- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?

ON A DAILY BASIS.

- Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?

NO.

- Have you supported similar applications in the past? If so, please supply name and docket number.

NO -

RECEIVED  
2012 JUN -9 AM 8:17  
SECRETARY'S BUREAU

**VERIFICATION OF STATEMENT**

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The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

Ibrahim mohamed  
(Signature)

6-26-12  
(Date)

IBRAHIM MOHAMED, MFT  
(Name, printed or typed)

MARRIAGE & FAMILY THERAPIST

**VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION**

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

RECEIVED  
20 JUL 2012  
CITY OF PHILADELPHIA  
BUR 2611

Dr. Wiltherkeen Auguste 215-424-2611  
Name of Supporter

5751 N - Broad Street, Philadelphia, PA, 19141  
Street Address City or Municipality County State Zip Code

Ibrahim - I. mohmed - Healthcare  
Name of Applicant  
Transportation Service, LLC

- Describe the type of transportation service needed.

Wheel chair and ambulatory from patient's homes to pharmacy

- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.

From patient's homes to pharmacy 5751 N - Broad Street, Philadelphia, PA 19141

- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?

on a daily basis.

- Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?

yes, but I need a consistent and dependable provider


- Have you supported similar applications in the past? If so, please supply name and docket number.

no.

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(Signature)  
WILTHERKEEN AUGUSTE  
(Name, printed or typed)

6-25-12  
(Date)

**VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION**

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Dr. Ibrahim Ibrahim 215-225-7330  
Name of Supporter

2755 Germantown Ave Philadelphia Pa 19133  
Street Address City or Municipality County State Zip Code

Ibrahim I - Mohamed - Healthcare  
Name of Applicant  
TRANSPORTATION SERVICE, LLC

• Describe the type of transportation service needed.  
Wheel chair and ambulatory from patients home to clinic.

• What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.  
From patients home to clinic 2755 Germantown Ave Philadelphia Pa 19133

• How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?  
Daily

• Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?  
Yes, But they do not come on time.

• Have you supported similar applications in the past? If so, please supply name and docket number.  
No.

RECEIVED  
2012 JUN -9 AM 11  
SECRETARY'S OFFICE

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[Signature]

Dr. Ibrahim Ibrahim  
(Name, printed or typed)

6/22/12  
(Date)

**VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION**

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

DR SAMUEL QUARTBY  
Name of Supporter

5023 SPRUCE ST PHILA PA 19139  
Street Address City or Municipality County State Zip Code

IBRAHIM MOHAMED - Healthcare Transportation, Service, LLC  
Name of Applicant

- Describe the type of transportation service needed.  
WHEEL CHAIR ACCESSIBLE
- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.  
FROM PATIENTS HOME TO THE OFFICE
- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?  
MONTHLY
- Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?  
YES, WERE NOT ON TIME
- Have you supported similar applications in the past? If so, please supply name and docket number. NO

SECRETARY'S BUREAU  
2012 JUL -9 AM 8:18  
REC'D

**VERIFICATION OF STATEMENT**

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

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[Signature]  
(Signature) DR SAMUEL QUARTBY  
(Name, printed or typed)  
215-471-1407

6-26-2012  
(Date)