Wisconsin Medicaid and BadgerCare Plus Mileage Reimbursement Trip Log

Mail or fax completed logs to:	**MTM, Inc.** Attention: Trip Logs 16 Hawk Ridge Dr. Lake St. Louis, MO 63367 Fax: 1-888-513-1610

Instructions:

- You must call MTM, Inc. prior to each health care appointment to schedule a trip for mileage reimbursement.
- Use this form to ask for payment of mileage after your appointments. You cannot be paid, unless this form is completed and returned to MTM, Inc.
- You will receive a trip number when scheduling rides with MTM, Inc. You must write the trip number down on this log. You must submit the trip log within **60 days** of the first trip listed on this form.
- Your health care provider must sign this log for each trip listed. Any health care provider at your appointment can sign this log. *This includes nurses, therapists, physician assistants, or nurse practitioner*s. It does not have to be the doctor.
- If you need a log for future trips, you can make copies of both sides of this blank log, download a log at www.mtm-inc.net/Wisconsin, or call 1-866-907-1493 and ask MTM, Inc. to mail you a blank log.
- A one-way trip is from your home to your appointment. A round trip is from your home to your appointment and then back home. For trips with an extra stop enter each stop on a separate line, for example:
  - 1st trip- home to doctor
  - 2nd trip- doctor to pharmacy
  - 3rd trip- pharmacy to home
- If you do not have a log when you go to your appointment, ask your health care provider for a note on their facility letterhead. The note should show the date of appointment and have health care provider's signature to verify you were seen. Once you have a trip log, attach the note from your health care provider in place of a signature.
- If your log is not complete MTM, Inc. will not be able to process your payment and the log will be returned to you. Mileage cannot be paid unless you received an approval from MTM, Inc. before your covered service and get a trip number.
- Make a copy of your completed log and keep it for your records.
- **If you have questions about how to complete this form or the mileage reimbursement process, please call MTM, Inc. at 1-866-907-1493.**

Patient Info	First Name:	Last Name:		ForwardHealth ID #:
	Address:			Phone:
	City:		State:	Zip:
Payment Info	ComData Card payable to :	Relationship to member: ☐ Self ☐ Other:		Date of Birth:
	Address:			Phone:
	City:		State:	Zip:

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Mileage Reimbursement Trip Log

Trip #1	Trip Number (Call MTM, Inc. for this prior to trip):	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where trip started: ☐ Home ☐ Other:			Health Care Provider Phone:
	Health Care Provider Name:	Health Care Provider Address:		
	I certify that this patient was seen for a Medicaid/BadgerCare Plus covered service.	**Signature & Title of Health care Provider:** ►		
Trip #2	Trip Number (Call MTM, Inc. for this prior to trip):	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where trip started: ☐ Home ☐ Other:			Health Care Provider Phone:
	Health Care Provider Name:	Health Care Provider Address:		
	I certify that this patient was seen for a Medicaid/BadgerCare Plus covered service.	**Signature & Title of Health care Provider:** ►		
Trip #3	Trip Number (Call MTM, Inc. for this prior to trip):	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where trip started: ☐ Home ☐ Other:			Health Care Provider Phone:
	Health Care Provider Name:	Health Care Provider Address:		
	I certify that this patient was seen for a Medicaid/BadgerCare Plus covered service.	**Signature & Title of Health Care Provider:** ►		
Trip #4	Trip Number (Call MTM, Inc. for this prior to trip):	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where trip started: ☐ Home ☐ Other:			Health Care Provider Phone:
	Health Care Provider Name:	Health Care Provider Address:		
	I certify that this patient was seen for a Medicaid/BadgerCare Plus covered service.	**Signature & Title of Health Care Provider:** ►		
Trip #5	Trip Number (Call MTM, Inc. for this prior to trip):	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where trip started: ☐ Home ☐ Other:			Health Care Provider Phone:
	Health Care Provider Name:	Health Care Provider Address:		
	I certify that this patient was seen for a Medicaid/BadgerCare Plus covered service.	**Signature & Title of Health Care Provider:** ►		
Trip #6	Trip Number (Call MTM, Inc. for this prior to trip):	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where trip started: ☐ Home ☐ Other:			Health Care Provider Phone:
	Health Care Provider Name:	Health Care Provider Address:		
	I certify that this patient was seen for a Medicaid/BadgerCare Plus covered service.	**Signature & Title of Health care Provider:** ►		

I have completed this form and I verify that the information on this trip log is true.	**Signature of Member, Parent/Guardian, or Representative:** ►