



Trip Log

Call 1-855-687-4786 (toll-free)

Facts about the passenger	First Name:		Last Name:		Medicaid #:
	Address:				Phone:
	City:		State:		Zip:

Facts about the driver	Name:		How is driver related to passenger: <input type="checkbox"/> Self <input type="checkbox"/> Other:		Date of Birth:
	Address:				Phone:
	City:		State:		Zip:

Trip #1	Trip Number (Call MTM for this before your trip):		Appointment Date:		Appointment Time:		Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way	
	Address where you were picked up: <input type="checkbox"/> Home <input type="checkbox"/> Other:						Health-care Provider Phone:	
	Health-care Provider Name:			Health-care Provider Address:				
	I certify that this patient was seen for a Medicaid-covered health service.			Signature & Title of Health-care Provider: ▶				

Trip #2	Trip Number (Call MTM for this before your trip):		Appointment Date:		Appointment Time:		Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way	
	Address where you were picked up: <input type="checkbox"/> Home <input type="checkbox"/> Other:						Health-care Provider Phone:	
	Health-care Provider Name:			Health care Provider Address:				
	I certify that this patient was seen for a Medicaid-covered health service.			Signature & Title of Health-care Provider: ▶				

Trip #3	Trip Number (Call MTM for this before your trip):		Appointment Date:		Appointment Time:		Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way	
	Address where you were picked up: <input type="checkbox"/> Home <input type="checkbox"/> Other:						Health-care Provider Phone:	
	Health-care Provider Name:			Health-care Provider Address:				
	I certify that this patient was seen for a Medicaid-covered health service.			Signature & Title of Health-care Provider: ▶				

Trip #4	Trip Number (Call MTM for this before your trip):		Appointment Date:		Appointment Time:		Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way	
	Address where you were picked up: <input type="checkbox"/> Home <input type="checkbox"/> Other:						Health-care Provider Phone:	
	Health-care Provider Name:			Health-care Provider Address:				
	I certify that this patient was seen for a Medicaid-covered health service.			Signature & Title of Health-care Provider: ▶				

Trip #5	Trip Number (Call MTM for this before your trip):		Appointment Date:		Appointment Time:		Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way	
	Address where you were picked up: <input type="checkbox"/> Home <input type="checkbox"/> Other:						Health-care Provider Phone:	
	Health-care Provider Name:			Health-care Provider Address:				
	I certify that this patient was seen for a Medicaid-covered health service.			Signature & Title of Health-care Provider: ▶				

I verify that the information on this Trip Log is true.	Signature of Participant, Parent/Guardian, or Representative: ▶	Mail or fax completed form <u>no later than 60 days</u> from the date of the appointment to:	MTM, Attention Trip Logs 16 Hawk Ridge Drive Lake St. Louis, MO 63367 Toll-free Fax: 1-888-513-1610
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Trip Log - Revised May 10, 2012. This communication contains information that is confidential and is solely for the use of the intended recipient. It may contain information that is privileged and exempt from disclosure under applicable law. If you are not the intended recipient of this communication, please be advised that any disclosure, copying, distribution or unauthorized use of this communication is strictly prohibited. Please also notify MTM at 1-888-561-8747 and return the communication to the originating address.

Trip #6	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you were picked up: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Health-care Provider Phone:
	Health-care Provider Name:		Health-care Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	Signature & Title of Health-care Provider: ▶		
Trip #7	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you were picked up: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Health-care Provider Phone:
	Health-care Provider Name:		Health care Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	Signature & Title of Health-care Provider: ▶		
Trip #8	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you were picked up: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Health-care Provider Phone:
	Health-care Provider Name:		Health-care Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	Signature & Title of Health-care Provider: ▶		
Trip #9	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you were picked up: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Health-care Provider Phone:
	Health-care Provider Name:		Health-care Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	Signature & Title of Health-care Provider: ▶		
Trip #10	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you were picked up: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Health-care Provider Phone:
	Health-care Provider Name:		Health-care Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	Signature & Title of Health-care Provider: ▶		
Trip #11	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you were picked up: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Health-care Provider Phone:
	Health-care Provider Name:		Health-care Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	Signature & Title of Health-care Provider: ▶		
Trip #12	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you were picked up: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Health-care Provider Phone:
	Health-care Provider Name:		Health-care Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	Signature & Title of Health-care Provider: ▶		

I verify that the information on this Trip Log is true.	Signature of Participant, Parent/Guardian, or Representative: ▶	Mail or fax completed form no later than 60 days from the date of the appointment to:	MTM, Attention Trip Logs 16 Hawk Ridge Drive Lake St. Louis, MO 63367 Toll-free Fax: 1-888-513-1610
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