# MTM

# Trip Log
## Call 1-855-687-4786 (toll-free)

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

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| **Facts about the driver** | Name: | How is driver related to passenger: ☐ Self ☐ Other: | Date of Birth: |
| | Address: | | Phone: |
| | City: | State: | Zip: |

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| **Trip #1** | Trip Number (Call MTM for this before your trip): | Appointment Date: | Appointment Time: | Type: ☐ Round Trip ☐ One-Way |
| | Address where you were picked up: ☐ Home ☐ 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:** ▶ | | |

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| **Trip #2** | Trip Number (Call MTM for this before your trip): | Appointment Date: | Appointment Time: | Type: ☐ Round Trip ☐ One-Way |
| | Address where you were picked up: ☐ Home ☐ 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:** ▶ | | |

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| **Trip #3** | Trip Number (Call MTM for this before your trip): | Appointment Date: | Appointment Time: | Type: ☐ Round Trip ☐ One-Way |
| | Address where you were picked up: ☐ Home ☐ 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:** ▶ | | |

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| **Trip #4** | Trip Number (Call MTM for this before your trip): | Appointment Date: | Appointment Time: | Type: ☐ Round Trip ☐ One-Way |
| | Address where you were picked up: ☐ Home ☐ 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:** ▶ | | |

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| **Trip #5** | Trip Number (Call MTM for this before your trip): | Appointment Date: | Appointment Time: | Type: ☐ Round Trip ☐ One-Way |
| | Address where you were picked up: ☐ Home ☐ 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:** ▶ | | |

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| 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**<br>**16 Hawk Ridge Drive**<br>**Lake St. Louis, MO 63367**<br>**Toll-free Fax: 1-888-513-1610** |

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| **Trip #6** | Trip Number (Call MTM for this before your trip): | Appointment Date: | Appointment Time: | Type: ☐ Round Trip ☐ One-Way |
| | Address where you were picked up: ☐ Home ☐ 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: ☐ Round Trip ☐ One-Way |
| | Address where you were picked up: ☐ Home ☐ 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: ☐ Round Trip ☐ One-Way |
| | Address where you were picked up: ☐ Home ☐ 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: ☐ Round Trip ☐ One-Way |
| | Address where you were picked up: ☐ Home ☐ 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: ☐ Round Trip ☐ One-Way |
| | Address where you were picked up: ☐ Home ☐ 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: ☐ Round Trip ☐ One-Way |
| | Address where you were picked up: ☐ Home ☐ 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: ☐ Round Trip ☐ One-Way |
| | Address where you were picked up: ☐ Home ☐ 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:** ▶ | | |

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|---|---|---|---|
| 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**<br>**16 Hawk Ridge Drive**<br>**Lake St. Louis, MO 63367**<br>**Toll-free Fax: 1-888-513-1610** |