



Reimbursement Trip Log

Mail, fax, or email completed logs to:

MTM, Attention: Trip Logs
16 Hawk Ridge Dr.
Lake St. Louis, MO 63367
Fax: 1-888-513-1610
Email: payme@mtm-inc.net

Instructions:

- You must call MTM on or before the day of your medical appointment. The number to call can be found on the back of your card or by calling member services. You will receive a trip number during this call. You will need to write the number down on this Trip Log. To be reimbursed, you must submit a Trip Log for all trip requests.
- Submit Trip Logs no more than 60 days past the date of the first appointment.
- Any healthcare professional at the facility can sign the Trip Log. *This includes nurses, therapists, physician assistants, or nurse practitioners.* It doesn't have to be the doctor.
- We suggest you make copies of your blank Reimbursement Trip Log. If you need a new copy of this form, you may call and request one be mailed to you, or you may download this form at www.memberportal.net.
- A one-way trip is from your home to the appointment. A round trip is from your home to the appointment and then back home. For trips with more stops, such as an extra trip from the first appointment to a second appointment before going back home, please enter each trip leg on a separate line, for example:
 - 1st leg- home to first doctor
 - 2nd leg- first doctor to second doctor
 - 3rd leg- second doctor to home
- If you don't have a Trip Log, ask your healthcare provider for a note on their facility letterhead. The note should state that you were seen and the date of the appointment. Once you have a new trip log, attach the note from your healthcare provider in place of a signature.
- Incomplete forms cannot be processed. It is your responsibility to complete this form correctly.
- Keep a copy of your Trip Log for your records.
- **Questions about the Reimbursement Process?** Please call: **1-888-513-0703**.

Member Info	First Name:	Last Name:	Medicaid #:
	Address:		Phone:
	City:	State:	Zip:
Payment Info	Make MTM Re-Loadable Debit Card payable to:	Relationship to Member: <input type="checkbox"/> Self <input type="checkbox"/> Other:	Date of Birth:
	Address:		Phone:
	City:	State:	Zip:



Reimbursement Trip Log (Continued)

Medicaid/Medicare ID#: _____

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:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	I certify that this patient was seen for a Medicaid covered health service.	Signature & Title of Healthcare 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:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	I certify that this patient was seen for a Medicaid covered health service.	Signature & Title of Healthcare 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:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	I certify that this patient was seen for a Medicaid covered health service.	Signature & Title of Healthcare 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:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	I certify that this patient was seen for a Medicaid covered health service.	Signature & Title of Healthcare 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:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	I certify that this patient was seen for a Medicaid covered health service.	Signature & Title of Healthcare Provider: ▶		
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:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	I certify that this patient was seen for a Medicaid covered health service.	Signature & Title of Healthcare 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:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	I certify that this patient was seen for a Medicaid covered health service.	Signature & Title of Healthcare Provider: ▶		
I have completed this form and I verify that the information on this trip log is true.		Signature of Member, Parent/Legal Guardian, or Representative: ▶		



ATTESTATION OF TRANSPORTATION PROVIDER QUALIFICATIONS
CONSOLIDATED APPROPRIATIONS ACT OF 2021

By signing this form, you attest that:

1. You are not banned from joining in any federal health care program. Listed on the MDHHS sanctioned provider list. Listed on the or U.S. Department of Health and Human Services exclusion list.
2. You have not been found guilty of a federal or state law after August 21, 1996, for a felony related to the unlawful
 - a. making,
 - b. distributing,
 - c. prescribing,
 - d. dispensingof a controlled substance.
3. You will tell Meridian of any felony related to a controlled substance and traffic violation that you are guilty of.
4. You have a valid driver's license.
5. In the past two years, you have not been found guilty of:
 - a. More than two moving violations
 - b. Operating While Intoxicated (OWI)
 - c. Driving Under the Influence (DUI)

Transporter/Driver (Name)

Signature

Date