



Reimbursement Trip Log

Email, fax, or mail completed logs to:

Email: payme@mtm-inc.net

Fax: 1-888-513-1610

MTM, Attention: Trip Logs
16 Hawk Ridge Dr.
Lake St. Louis, MO 63367

Instructions:

- You must call MTM on or before the day of your medical appointment. The number to call is 1-866-269-5927. You will receive a trip number during this call. You will need to write the number down on this Reimbursement Trip Log. To be reimbursed, you must submit a Reimbursement Trip Log for all trip requests.
- Submit Reimbursement Trip Logs no more than 60 days after the date of the first appointment.
- A healthcare professional at the facility must sign the Reimbursement Trip Log. This includes nurses, therapists, physician assistants, or nurse practitioners. It does not 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 download this form at www.memberportal.net, or you may call and request one be mailed to you.
- 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, please enter each trip leg on a separate line, for example:
 - 1st leg- trip from home to first doctor
 - 2nd leg- trip from first doctor to second doctor
 - 3rd leg- trip from second doctor to home
- Incomplete forms cannot be processed. It is your responsibility to complete this form correctly.
- Keep a copy of your Reimbursement Trip Log for your records.
- Questions about the reimbursement process? Please call: 1-888-513-0703.**

Participant Info	First Name:	Last Name:	MO HealthNet #:
	Address:		Phone:
	City:	State:	Zip:
Payment Info	Make payment to:	Relationship to Participant: <input type="checkbox"/> Self <input type="checkbox"/> Other:	Date of Birth:
	Address:		Phone:
	City:	State:	Zip:

Reimbursement Trip Log Revised August 2020. 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. If you, or someone you're helping, has questions about MTM, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 888-561-8747.

Si usted, o alguien a quien usted esté ayudando, tiene preguntas acerca de MTM, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888-561-8747. Non-discrimination. The client has a right to receive services in compliance with Title VI of the Civil Rights Act of 1964, 42 U.S.C.A., 2000d, et seq; 504 of the Rehabilitation Act of 1973, 29 U.S.C.A. 794; the Americans with Disabilities Act of 1990, 42 U.S.C.A. 12101, et seq; and all amendments to each, and all requirements imposed by the regulations issued pursuant to these Acts, in particular 45 C.F.R. Part 80 (relating to race, color, national origin), 45 C.F.R. Part 84 (relating to handicap), 45 C.F.R. Part 86 (relating to sex), and 45 C.F.R. Part 91 (relating to age).

	Reimbursement Log (Continued)
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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	
	Starting Address: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Healthcare Provider Phone:	
	Healthcare Provider Name:		Destination 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	
	Starting Address: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Healthcare Provider Phone:	
	Healthcare Provider Name:		Destination 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	
	Starting Address: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Healthcare Provider Phone:	
	Healthcare Provider Name:		Destination 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	
	Starting Address: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Healthcare Provider Phone:	
	Healthcare Provider Name:		Destination 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	
	Starting Address: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Healthcare Provider Phone:	
	Healthcare Provider Name:		Destination 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	
	Starting Address: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Healthcare Provider Phone:	
	Healthcare Provider Name:		Destination 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	
	Starting Address: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Healthcare Provider Phone:	
	Healthcare Provider Name:		Destination 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 Participant, Parent/Legal Guardian, or Representative: ▶
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