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: ☐ Self ☐ Other:		Date of Birth:
	Address:			Phone:
	City:	State:		Zip:

MTM

Reimbursement Log (Continued)

Trip #1	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Starting Address: ☐ Home ☐ 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: ☐ Round Trip ☐ One-Way
	Starting Address: ☐ Home ☐ 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: ☐ Round Trip ☐ One-Way
	Starting Address: ☐ Home ☐ 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: ☐ Round Trip ☐ One-Way
	Starting Address: ☐ Home ☐ 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: ☐ Round Trip ☐ One-Way
	Starting Address: ☐ Home ☐ 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: ☐ Round Trip ☐ One-Way
	Starting Address: ☐ Home ☐ 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: ☐ Round Trip ☐ One-Way
	Starting Address: ☐ Home ☐ 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:** ▶