Reimbursement Trip Log

Mail or fax completed logs to:

MTM, Attention: Trip Logs
16 Hawk Ridge Dr.
Lake St. Louis, MO 63367
Fax: 1-888-513-1610

Instructions:

- You must call MTM at **1-844-549-8353** prior to your medical appointment. You will receive a trip number from MTM 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 a Medicaid covered service. **You must also submit copies of your Payee's Social Security #, Payee's Driver's License #, Vehicle Insurance, and Vehicle Registration annually.**
- Submit Reimbursement Trip Logs no more than 60 days past the date of the first appointment. **Please sign your Reimbursement Trip Log at the bottom of the second page prior to submitting.**
- Any Medicaid enrolled healthcare professional at the facility can sign the Reimbursement Trip Log. *This includes nurses, therapists, physician assistants, or nurse practitioner*s. 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 and print this form at www.mtm-inc.net.
- Reimbursement funds will be provided electronically on your MTM Re-Loadable Debit Card.
- A one-way trip is from your home to the Medicaid appointment. A round trip is from your home to the Medicaid appointment and then back home. For trips with more stops, such as an extra trip from the first Medicaid appointment to a second Medicaid 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 Reimbursement Trip Log, ask your healthcare provider for a note on their facility letterhead. The note should state you were seen and the date of the appointment. Once you have a new Reimbursement Trip Log, attach the note from your healthcare provider in place of a signature.
- Incomplete Reimbursement Trip Logs cannot be processed. It is your responsibility to complete the Reimbursement Trip Log completely and correctly.
- Keep a copy of your Reimbursement Trip Log for your records.
- **Questions about the Reimbursement Process?** Please call: **1-888-513-0703.**

Member Info	First Name:	Last Name:		Medicaid ID #:
	Address:			Phone:
	City:		State:	Zip:

Payment Info	Make MTM Re-Loadable Debit Card payable to:	Payee's Social Security #:	Relationship to Member: ☐ Self ☐ Other:	Date of Birth:
	Address:			Phone:
	City:		State:	Zip:

Trip Log. This communication contains information that is confidential and is solely for the use of the intended Member. It may contain information that is privileged and exempt from disclosure under applicable law. If you are not the intended Member 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.

Reimbursement Trip Log (Continued)

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:			Healthcare Provider's Phone:
	Healthcare Provider's Name:	Healthcare Provider's 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
	Address where you were picked up: ☐ Home ☐ Other:			Healthcare Provider's Phone:
	Healthcare Provider's Name:	Healthcare Provider's 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
	Address where you were picked up: ☐ Home ☐ Other:			Healthcare Provider's Phone:
	Healthcare Provider's Name:	Healthcare Provider's 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
	Address where you were picked up: ☐ Home ☐ Other:			Healthcare Provider's Phone:
	Healthcare Provider's Name:	Healthcare Provider's 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
	Address where you were picked up: ☐ Home ☐ Other:			Healthcare Provider's Phone:
	Healthcare Provider's Name:	Healthcare Provider's 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
	Address where you were picked up: ☐ Home ☐ Other:			Healthcare Provider's Phone:
	Healthcare Provider's Name:	Healthcare Provider's 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
	Address where you were picked up: ☐ Home ☐ Other:			Healthcare Provider's Phone:
	Healthcare Provider's Name:	Healthcare Provider's 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:** ▶

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