Reimbursement Trip Log

Mail, fax, or email completed logs to:

MTM, Attention: Trip Logs
1110 Centre Pointe Curve, ste 220
Mendota Heights, MN 55120

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 ensure you have the correct trip number for each trip, & write the number on this Trip Log were indicated. 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. (Remitting the request later than 60 days could result in non-payment if there are errors or missing information)
- Any healthcare professional at the facility can sign the 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 & request one be mailed to you, or you may download this form at www.mtm-inc.net.
- A one-way trip is from your home to the appointment. A round trip is from your home to the appointment & 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 & 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.
- If you are a foster parent please check foster parent box in the Payment Info section.

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 payment to:	Relationship to Member: ☐ Self ☐ Other: ☐ Foster Parent Foster Care License #:	Date of Birth:
	Address:		Phone:
	City:	State:	Zip:

MTM	Reimbursement Trip Log (Continued)	Member Name

Trip #1	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time: A.M or P.M	Type: ☐ Round Trip ☐ One-Way
	Address where you were picked up: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	Beginning Odometer Reading:	Ending Odometer Reading:	License Plate #	
	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: A.M or P.M	Type: ☐ Round Trip ☐ One-Way
	Address where you were picked up: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	Beginning Odometer Reading:	Ending Odometer Reading:	License Plate #	
	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: A.M or P.M	Type: ☐ Round Trip ☐ One-Way
	Address where you were picked up: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	Beginning Odometer Reading:	Ending Odometer Reading:	License Plate #	
	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: A.M or P.M	Type: ☐ Round Trip ☐ One-Way
	Address where you were picked up: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	Beginning Odometer Reading:	Ending Odometer Reading:	License Plate #	
	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: A.M or P.M	Type: ☐ Round Trip ☐ One-Way
	Address where you were picked up: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	Beginning Odometer Reading:	Ending Odometer Reading:	License Plate #	
	I certify that this patient was seen for a Medicaid covered health service.	**Signature & Title of Healthcare Provider:** ▶		

I certify that I have received the reported transportation service.	**Signature of Member, Parent/Legal Guardian, or Representative:** ▶
I certify that I have accurately reported trip miles I actually drove & the dates & times I actually drove them. I understand that misreporting the miles driven & hours worked is fraud for which I could face criminal prosecution or civil proceedings.	**Signature of Driver:** ▶

Trip Log- Revised July 28, 2017.

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).