

Send completed logs to:

Email: payme@mtm-inc.net
Fax: 888-513-1610

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

Instructions:

- You must call MTM at 844-909-7433 before your medical appointment. 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 by the end of the month following your 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.
- If you had to pay for tolls or parking, please include your receipts with your Trip Log.
- We suggest you make copies of your blank WellSense NH Family and Friends Transportation 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 <https://www.mtm-inc.net/mileage-reimbursement/>
- 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 professional 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 888-513-0703.

Member Info	First Name:		Last Name:		Medicaid #:
	Address:				Phone:
	City:		State:	Zip:	
Payment Info	Make payment to:			Date of Birth:	
	Address:				Phone:
	City:		State:	Zip:	

25-0019

Trip Log Revised September 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).

Family and Friends Transportation Reimbursement Program Trip Log (Continued)

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: ▶		

Other Languages Available

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