Please Note: This form is not intended for use by MO HealthNet participants.

MTM
Medical Transportation Management, Inc.

Recipient's Medicaid # _____

Name: _____

Address: _____

City, St Zip: _____

Mail or fax completed form no later than 60 days from the date of the appointment to:
MTM Transportation - GMR Dept
16 Hawk Ridge Dr
Lake St Louis, MO 63367
Fax: 1-888-513-1610

Make my check payable to: _____

Address: _____ City, St Zip _____

Phone #: _____

Relationship to Medicaid Recipient, please circle one: Medicaid Recipient Foster Care Provider Parent/Guardian Volunteer Driver PCA

Appointment Date	Appointment Time	Address where you were picked up (if this is your home address write HOME)	Name, Address & Phone Number of Health Care Provider you saw **All information must be complete**	Round Trip Yes or No	I certify that this patient was seen for a Medicaid covered health service. **Signature & Title of Health Care Practitioner**

I have completed this form and I verify that the information on this Trip Log is true: _____

Signature of recipient, recipients parent gaurdian or representative

PLEASE KEEP A COPY OF YOUR TRIP LOGS FOR YOUR RECORDS. INCOMPLETE FORMS CAN NOT BE PROCESSED. It is your responsibility to complete all colums correctly. MTM will send a check for the completed items. MTM will return any incomplete forms for completion.

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