

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 columns correctly. MTM will send a check for the completed items. MTM will return any incomplete forms for completion.

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.

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