Reimbursement Log

Email, fax, or mail completed logs to:

Email: payme@mtm-inc.net

Fax: 1-888-513-1610

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

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 write the number down on this Trip Log. 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.
- Any healthcare professional at the facility must 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 download this form at **www.memberportal.net**, or you may call and request one be mailed to you.
- 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
- 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: **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:		Date of Birth:
	Address:			Phone:
	City:	State:		Zip:

MTM

Reimbursement Log (Continued)

Trip #1	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Starting Address: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Destination 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
	Starting Address: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Destination 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
	Starting Address: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Destination 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
	Starting Address: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Destination 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
	Starting Address: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Destination 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
	Starting Address: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Destination 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
	Starting Address: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Destination 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:** ▶