# Mileage Reimbursement Trip Log

home state health™

**Mail or fax completed logs to:**

**MTM**, Attention: Trip Logs
16 Hawk Ridge Dr.
Lake St. Louis, MO 63367
Fax: 1-888-513-1610

## Instructions:

- To be paid for mileage, you must submit this log for all trips.
- Before your appointment, you must call Home State Health Plan's free transportation number, 1-855-694-4663. You will receive a trip number during this call. You will write the trip number down on this form.
- MTM must receive the form no more than 60 days past the date of the first appointment.
- Nurses, therapists or assistants can sign the form. It does not have to be the doctor.
- We suggest you make copies of this blank form. If you need a new copy, you may call and request one be mailed to you, or you may find 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 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 do not have a trip log at the time of your appointment, ask your doctor for a note on their facility letterhead stating you were seen and the date of the appointment. Once a trip log is received in the mail, attach the note from your doctor in place of a signature.
- Incomplete forms cannot be processed and will be returned to you. It is your responsibility to complete this form correctly. MTM will send payment for the completed items.
- Keep a copy of your trip log for your records.
- **Questions about the reimbursement process?** Please call: **1-888-513-0703.**

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| **Recipient Info** | First Name: | Last Name: | | MO HealthNet #: |
| | Address: | | | Phone: |
| | City: | State: | | Zip: |
| **Payment Info** | Make check payable to: | Relationship to recipient: ☐ Self ☐ Other: | | Date of Birth: |
| | Address: | | | Phone: |
| | City: | State: | | Zip: |

# MTM Mileage Reimbursement Trip Log (Continued)

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| **Trip #1** | Trip Number (Call MTM for this before your trip): | Appointment Date: | Appointment Time: | Type: ☐ Round Trip ☐ One-Way |
| | Address where you were picked up: ☐ Home ☐ Other: | | | Medical Provider Phone: |
| | Medical Provider Name: | Medical Provider Address: | | |
| | I certify that this patient was seen for a MO HealthNet covered 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 |
| | Address where you were picked up: ☐ Home ☐ Other: | | | Medical Provider Phone: |
| | Medical Provider Name: | Medical Provider Address: | | |
| | I certify that this patient was seen for a MO HealthNet covered 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 |
| | Address where you were picked up: ☐ Home ☐ Other: | | | Medical Provider Phone: |
| | Medical Provider Name: | Medical Provider Address: | | |
| | I certify that this patient was seen for a MO HealthNet covered 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 |
| | Address where you were picked up: ☐ Home ☐ Other: | | | Medical Provider Phone: |
| | Medical Provider Name: | Medical Provider Address: | | |
| | I certify that this patient was seen for a MO HealthNet covered 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 |
| | Address where you were picked up: ☐ Home ☐ Other: | | | Medical Provider Phone: |
| | Medical Provider Name: | Medical Provider Address: | | |
| | I certify that this patient was seen for a MO HealthNet covered 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 |
| | Address where you were picked up: ☐ Home ☐ Other: | | | Medical Provider Phone: |
| | Medical Provider Name: | Medical Provider Address: | | |
| | I certify that this patient was seen for a MO HealthNet covered 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 |
| | Address where you were picked up: ☐ Home ☐ Other: | | | Medical Provider Phone: |
| | Medical Provider Name: | Medical Provider Address: | | |
| | I certify that this patient was seen for a MO HealthNet covered service. | **Signature & Title of Healthcare Provider:** ▶ | | |

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| I have completed this form and I verify that the information on this trip log is true. | **Signature of Participant, Parent/Guardian, or Representative:** ▶ |