



# Reimbursement Log

In order to qualify for Gas Mileage Reimbursement (GMR) or Meals Reimbursement, you must receive a trip ID number prior to your appointment. *Note: A trip ID number alone does not guarantee you will receive reimbursement.*

**Email, fax, or mail completed logs to:**

**Email:** [payme@mtm-inc.net](mailto:payme@mtm-inc.net)

**Fax:** 1-888-513-1610

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

Examples of a Trip Request

- One-way trip: your home to the appointment.
- Round trip: 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 like below:

- 1<sup>st</sup> leg: home to first doctor
- 2<sup>nd</sup> leg: first doctor to second doctor
- 3<sup>rd</sup> leg: second doctor to home

Before Appointment

- You must call MTM on, or before, the day of your medical appointment to receive a trip ID number which is required for any reimbursement.
- We suggest you make copies of your blank Trip Log. If you need a new copy of this form, you may download this form at [www.memberportal.net](http://www.memberportal.net), or you may call and request one to be mailed to you.

Day of Appointment

- You will need to write each trip ID number on the Trip Log. Any healthcare professional at the facility must sign the Reimbursement Log. *This includes nurses, therapists, physician assistants, or nurse practitioners.* It doesn't have to be the doctor.

After Appointment

- A Trip Log must be submitted for all trip requests.
  - Incomplete forms cannot be processed. It is your responsibility to complete this Trip Log correctly.
- Submit Trip Logs no more than 60 days past the date of the first appointment.
- Keep a copy of your Trip Log for your records.
- An appointment may be verified and payment will be denied if MTM cannot verify you went to the appointment.

**Questions about the reimbursement process? Please call: 1-888-513-0703.**

<b>Member Info</b>	First Name:	Last Name:	Medicaid #:
	Address:		Phone:
	City:	State:	Zip:
<b>Payment Info</b>	Make MTM Re-Loaded Debit Card payable to:	Relationship to Member: <input type="checkbox"/> Self <input type="checkbox"/> Other:	Date of Birth:
	Address:		Phone:
	City:	State:	Zip:



## Reimbursement Log (Continued)

<b>Trip #1</b>	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Starting Address: <input type="checkbox"/> Home <input type="checkbox"/> Other:	Healthcare Provider Phone:		
	Healthcare Provider Name:	Destination Address:		
	I certify that this patient was seen for a Medicaid covered health service.	<b>Signature &amp; Title of Healthcare Provider:</b> ▶		
<b>Trip #2</b>	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Starting Address: <input type="checkbox"/> Home <input type="checkbox"/> Other:	Healthcare Provider Phone:		
	Healthcare Provider Name:	Destination Address:		
	I certify that this patient was seen for a Medicaid covered health service.	<b>Signature &amp; Title of Healthcare Provider:</b> ▶		
<b>Trip #3</b>	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Starting Address: <input type="checkbox"/> Home <input type="checkbox"/> Other:	Healthcare Provider Phone:		
	Healthcare Provider Name:	Destination Address:		
	I certify that this patient was seen for a Medicaid covered health service.	<b>Signature &amp; Title of Healthcare Provider:</b> ▶		
<b>Trip #4</b>	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Starting Address: <input type="checkbox"/> Home <input type="checkbox"/> Other:	Healthcare Provider Phone:		
	Healthcare Provider Name:	Destination Address:		
	I certify that this patient was seen for a Medicaid covered health service.	<b>Signature &amp; Title of Healthcare Provider:</b> ▶		
<b>Trip #5</b>	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Starting Address: <input type="checkbox"/> Home <input type="checkbox"/> Other:	Healthcare Provider Phone:		
	Healthcare Provider Name:	Destination Address:		
	I certify that this patient was seen for a Medicaid covered health service.	<b>Signature &amp; Title of Healthcare Provider:</b> ▶		
<b>Trip #6</b>	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Starting Address: <input type="checkbox"/> Home <input type="checkbox"/> Other:	Healthcare Provider Phone:		
	Healthcare Provider Name:	Destination Address:		
	I certify that this patient was seen for a Medicaid covered health service.	<b>Signature &amp; Title of Healthcare Provider:</b> ▶		
<b>Trip #7</b>	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Starting Address: <input type="checkbox"/> Home <input type="checkbox"/> Other:	Healthcare Provider Phone:		
	Healthcare Provider Name:	Destination Address:		
	I certify that this patient was seen for a Medicaid covered health service.	<b>Signature &amp; Title of Healthcare Provider:</b> ▶		

I have completed this form and I verify that the information on this trip log is true.	<b>Signature of Member, Parent/Legal Guardian, or Representative:</b> ▶
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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).