Mileage Reimbursement Trip Log

Instructions:

- You must call MTM at 1-866-331-6004 on or before the day of your medical appointment. You will receive a trip number from MTM during this call. You will need to write the number down on this Trip Log.

Mail or fax completed logs to:

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

- To be paid for mileage, you must submit a trip log for a Medicaid covered service.
- Submit Trip Logs no more than 60 days past the date of the first appointment.
- Any Medicaid enrolled healthcare professional at the facility can 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 Mileage Reimbursement Trip Log. If you need a new copy of this form, you may call and request one be mailed to you, or you may download and print this form at www.mtm-inc.net.
- Mileage is reimbursed based on IRS standard mileage rates. Reimbursement funds will be provided electronically on the beneficiary's COMDATA Mastercard provided by MTM.
- A one-way trip is from your home to the Medicaid appointment. A round trip is from your home to the Medicaid appointment and then back home. For trips with more stops, such as an extra trip from the first Medicaid appointment to a second Medicaid 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 don't have a Trip Log, 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. It is your responsibility to complete this form correctly. MTM will release funds for completed trips only to your COMDATA Mastercard.
- Keep a copy of your Trip Log for your records.
- **Questions about the reimbursement process?** Please call: **1-866-331-6004.**

Beneficiary Info	First Name:	Last Name:		Medicaid ID #:
	Address:			Phone:
	City:	State:		Zip:
Payment Info	Make COMDATA Mastercard payable to:	Relationship to Beneficiary: ☐ Self ☐ Other:		Date of Birth:
	Address:			Phone:
	City:	State:		Zip:

MTM Mileage Reimbursement Trip Log (Continued)

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 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
	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 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
	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 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
	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 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
	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 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
	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 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
	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 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 Participant, Parent/Guardian, or Representative:** ▶