



**MTM**  
 Medical Transportation  
 Management, Inc.

Member's HealthCare USA ID #: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, St Zip: \_\_\_\_\_

Mail or fax completed form no  
 later than 60 days from the  
 date of the appointment to:  
 MTM Transportation - BSG 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 HealthCare USA Member (circle one): Member Foster Care Provider Parent/Guardian Volunteer Driver PCA

**CIRCLE ONE CHOICE ABOVE TO SHOW RELATION OF HealthCare USA Member TO PERSON TO BE PAID**

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 <b>All information must be complete</b>	Round Trip Yes or No	I certify that this patient was seen for a MO HealthNet Managed Care covered health service. <b>Signature &amp; Title of Health Care Practitioner</b>

I have completed this form and I verify that the information on this Trip Log is true: \_\_\_\_\_  
 Signature of Member, Member's parent guardian or representative

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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