



Wisconsin Medicaid and BadgerCare Plus Meal Log

Mail or fax completed logs to:

MTM, Inc.
Attention: Meal Logs
16 Hawk Ridge Drive
Lake Saint Louis, MO 63367
Fax: 1-888-513-1610

Instructions:

- You must call MTM, Inc. prior your health care appointment for trips that will need meals as soon as possible, but at least 2 business days in advance. You can ask MTM, Inc, to approve meals for any trips in current month and the following month.
- Use this form to ask for payment of meals after your appointment. You cannot be paid, unless this form is completed and returned to MTM, Inc.
- You will receive a trip number when scheduling rides with MTM, Inc. You must write the trip number down on this log. You must submit the meal log within 60 days of the first trip listed on this form.
- Your health care provider must sign this log for each trip listed. Any health care provider at your appointment can sign this log. *This includes nurses, therapists, physician assistants, or nurse practitioners.* It does not have to be the doctor.
- If you need a log for future trips, you can make copies of both sides of this blank log, download a log at www.mtm-inc.net/Wisconsin, or call 1-866-907-1493 and ask MTM, Inc. to mail you a blank log. A one-way trip is from your home to your appointment. A round trip is from your home to your appointment and then back home. For trips with an extra stop enter each stop on a separate line, for example:
 - 1st trip- home to doctor
 - 2nd trip- doctor to pharmacy
 - 3rd trip- pharmacy to home
- If you do not have a log when you go to your appointment, ask your health care provider for a note on their facility letterhead. The note should show the date of appointment and have health care provider’s signature to verify you were seen. Once you have a Meal log, attach the note from your health care provider in place of a signature.
- If your log is not complete, MTM, Inc. will not be able to process your payment and the log will be returned to you. Meals cannot be paid unless you received an approval from MTM, Inc. before your covered service and get a trip number.
- Make a copy of your completed Meal log and keep it for your records.
- If you have questions about how to complete this form or the meal reimbursement process, please call MTM, Inc. at 1-866-907-1493.**

Member Info	First Name:	Last Name:	ForwardHealth ID #:
	Address:		Phone:
	City:	State:	Zip:
Payment Info	ComData Card payable to:	Relationship to member: <input type="checkbox"/> Self <input type="checkbox"/> Other:	Date of Birth:
	Address:		Phone:
	City:	State:	Zip:



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Meal Log

Trip #1	Trip Number (Call MTM, Inc. for this prior to trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where trip started: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Health care Provider Phone:
	Health care Provider Name:	Health care Provider Address:		
	I certify that this patient was seen for a Medicaid/BadgerCare Plus covered health service.	Signature & Title of Health care Provider: ▶		
Trip #2	Trip Number (Call MTM, Inc. for this prior to trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where trip started: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Health care Provider Phone:
	Health care Provider Name:	Health care Provider Address:		
	I certify that this patient was seen for a Medicaid/BadgerCare Plus covered health service.	Signature & Title of Health care Provider: ▶		
Trip #3	Trip Number (Call MTM, Inc. for this prior to trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where trip started: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Health care Provider Phone:
	Health care Provider Name:	Health care Provider Address:		
	I certify that this patient was seen for a Medicaid/BadgerCare Plus covered health service.	Signature & Title of Health care Provider: ▶		
Trip #4	Trip Number (Call MTM, Inc. for this prior to trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where trip started: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Health care Provider Phone:
	Health care Provider Name:	Health care Provider Address:		
	I certify that this patient was seen for a Medicaid/BadgerCare Plus covered health service.	Signature & Title of Health care Provider: ▶		
Trip #5	Trip Number (Call MTM, Inc. for this prior to trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where trip started: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Health care Provider Phone:
	Health care Provider Name:	Health care Provider Address:		
	I certify that this patient was seen for a Medicaid/BadgerCare Plus covered health service.	Signature & Title of Health care Provider: ▶		
Trip #6	Trip Number (Call MTM, Inc. for this prior to trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where trip started: <input type="checkbox"/> Home <input type="checkbox"/> Other:			Health care Provider Phone:
	Health care Provider Name:	Health care Provider Address:		
	I certify that this patient was seen for a Medicaid/BadgerCare Plus covered health service.	Signature & Title of Health care Provider: ▶		
I have completed this form and I verify that the information on this Meal Log is true.		Signature of Member, Parent/Guardian, or Representative: ▶		