ITP Service Record (Claim Form)

*Client Name:	Client Telephone:	*Client Medicaid:
Medicaid Member's Name		123456789
*ITP Name:	ITP Telephone:	*ITP MTI Number:
ITP Driver/Payee's Name		ITP Driver/Payee's Driver License Number

Trip #1			
From:	To:	Miles:	Amount:
From:	To:	Miles:	Amount:
*Authorization Number:	*Appointment Date/Time:	Total Miles:	Total Amount:
Trip Number from MTM	Date/Time		
Health Care Provider NPI:	Health Care Provider Telephone:	*Health Care Provider Name:	
		Doctor's Name	
I certify that this patient was seen for a Medicaid/CSHCN covered health care service.	*Signature & Title of Health Care Provider:	*Date Signed:	
	Healthcare Provider Signature(can be any facility staff member	Date Signed by Healthcare Provider	

Trip #2			
From:	To:	Miles:	Amount:
From:	To:	Miles:	Amount:
*Authorization Number:	*Appointment Date/Time:	*Total Miles:	Total Amount:
Trip Number from MTM	Date/Time		
Health Care Provider NPI:	Health Care Provider Telephone:	*Health Care Provider Name:	
	( )	Doctor's Name	
I certify that this patient was seen for a Medicaid/CSHCN covered health care service.	*Signature & Title of Health Care Provider:	*Date Signed:	
	Healthcare Provider Signature(can be any facility staff member	Date Signed by Healthcare Provider	

ITP Drivers: *To process your mileage claim, please ensure that fields with an asterisks (*) are filled in. Please note that the allowable mileage that may be claimed for reimbursement Is calculated by the managed transportation organization using an online mileage application.*

AFFIDAVIT: This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim is from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws. I hereby certify that this claim contains no willful misrepresentation or falsification and that the information I have given is true and correct to the best of my knowledge and belief. **I attest that I have complied with all of the provisions of the Individual Transportation Participant Agreement when providing the transportation services for which I am seeking reimbursement.**

ITP Driver/Payee's Signature _____ Date Signed by ITP Driver/Payee _____

***Signature of Individual Transportation Participant (ITP)** ***Date**

Please retain a copy for your records. All forms must be mailed or faxed to:

MTM, Inc.
16 Hawk Ridge Dr.
Lake St. Louis, MO 63367
Fax Number: 888-407-0936/**Web Mail:** txgmr@mtm-inc.net