Bus Trip Log
Call 1-844-879-7341 (toll-free)

The bus trip log must be turned in to the MTM Bus Pass Representative before bus passes for future trips will be issued. It is your responsibility to complete all columns correctly.

Facts about the passenger	First Name:	Last Name:	Medicaid #:
	Address:		Phone:
	City:	State:	Zip:

Trip #1	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you began your trip: ☐ Home ☐ Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	**Signature & Title of Healthcare Provider:** ►	
Trip #2	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you began your trip: ☐ Home ☐ Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	**Signature & Title of Healthcare Provider:** ►	
Trip #3	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you began your trip: ☐ Home ☐ Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	**Signature & Title of Healthcare Provider:** ►	
Trip #4	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you began your trip: ☐ Home ☐ Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	**Signature & Title of Healthcare Provider:** ►	
Trip #5	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you began your trip: ☐ Home ☐ Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	**Signature & Title of Healthcare Provider:** ►	

I verify that the information on this Trip Log is true.	**Signature of Member or Parent/Guardian** ►	**MTM** **750 Pilot Road, Suites G&H** **Las Vegas, NV 89119**

Trip #6	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you began your trip: ☐ Home ☐ Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	**Signature & Title of Healthcare Provider:** ▶	
Trip #7	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you began your trip: ☐ Home ☐ Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	**Signature & Title of Healthcare Provider:** ▶	
Trip #8	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you began your trip: ☐ Home ☐ Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	**Signature & Title of Healthcare Provider:** ▶	
Trip #9	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you began your trip: ☐ Home ☐ Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	**Signature & Title of Healthcare Provider:** ▶	
Trip #10	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you began your trip: ☐ Home ☐ Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	**Signature & Title of Healthcare Provider:** ▶	
Trip #11	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you began your trip: ☐ Home ☐ Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	**Signature & Title of Healthcare Provider:** ▶	
Trip #12	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you began your trip: ☐ Home ☐ Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	**Signature & Title of Healthcare Provider:** ▶	

I verify that the information on this Trip Log is true.	**Signature of Member or Parent/Guardian:** ▶	**MTM** **750 Pilot Road, Suites G&H** **Las Vegas, NV 89119**

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 q; 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 q; 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).

