



# 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.

<b>Facts about the passenger</b>	First Name:		Last Name:		Medicaid #:	
	Address:				Phone:	
	City:		State:		Zip:	
<b>Trip #1</b>	Appointment Date:		Appointment Time:		Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way	
	Address where you began your trip: <input type="checkbox"/> Home <input type="checkbox"/> Other:				Healthcare Provider Phone:	
	Healthcare Provider Name:		Healthcare Provider Address:			
	I certify that this patient was seen for a Medicaid-covered health service.		<b>Signature &amp; Title of Healthcare Provider:</b> ▶			
<b>Trip #2</b>	Appointment Date:		Appointment Time:		Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way	
	Address where you began your trip: <input type="checkbox"/> Home <input type="checkbox"/> Other:				Healthcare Provider Phone:	
	Healthcare Provider Name:		Healthcare Provider Address:			
	I certify that this patient was seen for a Medicaid-covered health service.		<b>Signature &amp; Title of Healthcare Provider:</b> ▶			
<b>Trip #3</b>	Appointment Date:		Appointment Time:		Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way	
	Address where you began your trip: <input type="checkbox"/> Home <input type="checkbox"/> Other:				Healthcare Provider Phone:	
	Healthcare Provider Name:		Healthcare Provider Address:			
	I certify that this patient was seen for a Medicaid-covered health service.		<b>Signature &amp; Title of Healthcare Provider:</b> ▶			
<b>Trip #4</b>	Appointment Date:		Appointment Time:		Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way	
	Address where you began your trip: <input type="checkbox"/> Home <input type="checkbox"/> Other:				Healthcare Provider Phone:	
	Healthcare Provider Name:		Healthcare Provider Address:			
	I certify that this patient was seen for a Medicaid-covered health service.		<b>Signature &amp; Title of Healthcare Provider:</b> ▶			
<b>Trip #5</b>	Appointment Date:		Appointment Time:		Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way	
	Address where you began your trip: <input type="checkbox"/> Home <input type="checkbox"/> Other:				Healthcare Provider Phone:	
	Healthcare Provider Name:		Healthcare Provider Address:			
	I certify that this patient was seen for a Medicaid-covered health service.		<b>Signature &amp; Title of Healthcare Provider:</b> ▶			
I verify that the information on this Trip Log is true.		<b>Signature of Member or Parent/Guardian</b> ▶			<b>MTM</b> 750 Pilot Road, Suites G&H Las Vegas, NV 89119	

**Trip Log - Revised January, 2017.** 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.

Trip #6	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you began your trip: <input type="checkbox"/> Home <input type="checkbox"/> Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	<b>Signature &amp; Title of Healthcare Provider:</b> ▶	
Trip #7	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you began your trip: <input type="checkbox"/> Home <input type="checkbox"/> Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	<b>Signature &amp; Title of Healthcare Provider:</b> ▶	
Trip #8	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you began your trip: <input type="checkbox"/> Home <input type="checkbox"/> Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	<b>Signature &amp; Title of Healthcare Provider:</b> ▶	
Trip #9	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you began your trip: <input type="checkbox"/> Home <input type="checkbox"/> Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	<b>Signature &amp; Title of Healthcare Provider:</b> ▶	
Trip #10	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you began your trip: <input type="checkbox"/> Home <input type="checkbox"/> Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	<b>Signature &amp; Title of Healthcare Provider:</b> ▶	
Trip #11	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you began your trip: <input type="checkbox"/> Home <input type="checkbox"/> Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	<b>Signature &amp; Title of Healthcare Provider:</b> ▶	
Trip #12	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you began your trip: <input type="checkbox"/> Home <input type="checkbox"/> Other:		Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:	
	I certify that this patient was seen for a Medicaid-covered health service.	<b>Signature &amp; Title of Healthcare Provider:</b> ▶	
I verify that the information on this Trip Log is true.	<b>Signature of Member or Parent/Guardian:</b> ▶		<b>MTM</b> <b>750 Pilot Road, Suites G&amp;H</b> <b>Las Vegas, NV 89119</b>

*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).*