



Mileage Reimbursement Trip Log

Mail, fax, or email completed logs to:

National MedTrans, Attention: Mileage Reimbursement
280 West 10200 South Sandy, UT 84070

Fax: (631) 615-4011

Email: friendsandfamilyenrollment@natmedtrans.com

Instructions:

- You must call National MedTrans on or before the day of your medical appointment. The number to call can be found on the back of your health plan ID card. You will receive a trip number during this call. You will need to write the number down on this Trip Log for all completed trip instances in order to be reimbursed.
- Submit Trip Logs no more than 60 days past the date of each appointment.
- Any healthcare professional at the facility can sign the Trip Log. *This includes nurses, therapists, physician assistants, or nurse practitioners.* It does not have to be the medical provider.
- We suggest you make copies of this blank Mileage Reimbursement Trip Log. If you need a new copy of this form, you may call and request one be mailed to you, or you may download this form from <https://www.nationalmedtrans.com/> and selecting your State and Health plan.
- A one-way trip is from your home to the appointment. A round trip is from your home to the appointment and then back home. For trips with more stops, such as an extra trip from the first appointment to a second appointment before going back home, please enter each trip leg on a separate line, for example:
 - 1st leg - home to first doctor
 - 2nd leg - first doctor to second doctor
 - 3rd leg - second doctor to home
- If you don't have a Trip Log, ask your healthcare provider for a note on their facility letterhead. The note should state that you were seen and the date of the appointment. Once you have a new trip log, attach the signed note from your healthcare provider in place of a signature for the corresponding trip instance.
- Incomplete forms cannot be processed. It is your responsibility to complete this form correctly.
- Keep a copy of your Trip Log for your records.
- Questions about the Mileage Reimbursement Process? Please call: 1 (844) 529-1801 ext. 1962**

Member Info	First Name:	Last Name:	MO HealthNet ID:	
	Address:		Phone:	
	City:		State:	Zip:
Payment Info	Make payment to:	Relationship to Member:		Date of Birth:
			<input type="checkbox"/> Self <input type="checkbox"/> Other:	
	Address:		Phone:	
	City:		State:	Zip:

MedTrans Trip Log - Revised 09/06/2018. 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 National MedTrans at 1 (844) 714-2219 and return the communication to the originating address.

If you, or someone you're helping, has questions about National MedTrans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1 (866) 292-0359. Si usted, o alguien a quien usted esté ayudando, tiene preguntas acerca de National MedTrans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1 (866) 292-0359. 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 seq; 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 seq; 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).



Reimbursement Trip Log (Continued)

Trip #1	Trip Number (Call National MedTrans for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you were picked up: <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 MO HealthNet covered health service.	Signature & Title of Healthcare Professional: ▶		
Trip #2	Trip Number (Call National MedTrans for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you were picked up: <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 MO HealthNet covered health service.	Signature & Title of Healthcare Professional: ▶		
Trip #3	Trip Number (Call National MedTrans for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you were picked up: <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 MO HealthNet covered health service.	Signature & Title of Healthcare Professional: ▶		
Trip #4	Trip Number (Call National MedTrans for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you were picked up: <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 MO HealthNet covered health service.	Signature & Title of Healthcare Professional: ▶		
Trip #5	Trip Number (Call National MedTrans for this before your trip):	Appointment Date:	Appointment Time:	Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One-Way
	Address where you were picked up: <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 MO HealthNet covered health service.	Signature & Title of Healthcare Professional: ▶		
I verify that the information on this trip log is true.		Signature of Member, Parent/Legal Guardian, or Representative: ▶		

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UnitedHealthcare does not discriminate based on race, color, national origin, sex, age or disability.

We provide communication help at no cost for people with disabilities. This includes materials with large print. It includes audio, electronic and other formats. We also have American sign language interpreters. If English is not your main language, you may ask for an interpreter. We also have materials in other languages.

To ask for help, call 1-866-292-0359, TTY 711. Hours are Monday to Friday, 8:00 a.m. to 5:00 p.m.

ATTENTION: If you do not speak English, language assistance services, at no cost to you, are available. Call 1-866-292-0359, TTY 711.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-292-0359, TTY 711.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-292-0359，TTY 711。

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