TRIP LOG

Send completed form via mail or fax
Mail to: **MNet attn: Care Management ▪ 149 Thompson Ave E Ste. 150 ▪ West St. Paul ▪ MN ▪ 55118**
Fax: **651-203-1262** Questions? Call **651.645.9254** ext. **8172**
***Trip log must be submitted within 10 months of the date of service to be eligible for reimbursement**

Person completing form relationship to recipient:

☐ Self ☐ PCA ☐ Parent Guardian ☐ Volunteer ☐ Foster Parent ☐ Other:__________ Receipts enclosed? ☐YES ☐NO **prior approval required*

RECIPIENT INFORMATION

Name:__________ __________

MA #:__________ DOB:__________

Address:__________

City:__________ Zip:__________

MAKE CHECK PAYABLE TO:

Name:__________

Address:__________

City:__________ Zip:__________

Phone:__________

Time	Date	Starting Address If home, write "HOME"	Destination / Facility Info **Name, Address & Phone**	Provider Type i.e. pediatrician, OB/GYN, family practice	Round Trip	Signature & Title from Healthcare Staff ***by signing you certify the patient was seen for an MA billable service**
					YES	
					NO	
					YES	
					NO	
					YES	
					NO	
					YES	
					NO	
					YES	
					NO	

I, ______________________________, completed this form and verify that all the information on this trip log is true.
(print name)

Signature: ______________________________ **Date:** __________

****All*** requested information for each trip must be provided to ensure accurate and timely processing. Incomplete information may result in ***non payment***.