Trip Log

SmartLink

Recipient's MA Number: _____

Name & Address _____

_____

Phone Number: _____

Make Check Payable to: _____

Address: _____

_____

Phone Number: _____

Relationship to MA Recipient: Parent/Guardian MA Recipient
(circle one) Volunteer Foster Care Provider

Mail or fax completed form NO LATER than *30-days* from date of appointment

SmartLink
1615 Weston Court
Shakopee, MN 55379
Ph: (952) 496-8341 option 2
Fax: (612) 656-3032
Email: Transit@co.scott.mn.us

Please complete each box on a line. Incomplete lines cannot be reimbursed and will be returned to you.
Questions, please call (952) 496-8341 option 2 Ask for MA Reimbursement

Date of Appt	Appt Time	Origination, Address (if home, please write home)	Name, Address, Phone Number of MA eligible health service	Round Trip? Yes/No	I certify that this person was seen for a MA covered health service. Signature/Title of Healthcare Provider	Park/Meal receipts? Yes/No

Date Received: _____ Vendor Number: _____

I certify and swear that I have accurately reported in this mileage log that are the miles I actually drove and the dates and times I actually drove them. I understand that misreporting the miles driven and hours worked is fraud for which I could face criminal prosecution or civil proceedings.

**For complete information on reimbursements, visit:
SmartLinkTransit.com

_____ _____
Signature Date

SmartLink

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Signature _____ Date _____