

Trip Log



Recipient's MA Number: _____ Name & Address _____ _____ Phone Number: _____ Make Check Payable to: _____ Address: _____ _____ Phone Number: _____	Mail or fax completed form <u>NO LATER</u> than <u>30-days</u> from date of appointment SmartLink 200 4th Ave. West Shakopee, MN 55379 Ph: (952) 496-8341 option 2 Fax: (952) 279-6110 Email: Transit@co.scott.mn.us
Relationship to MA Recipient: Parent/Guardian MA Recipient (circle one) Volunteer Foster Care Provider	

**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 the trips outlined were actually performed. I understand that misreporting the trip or if I did not attend the appointments are fraud for which I could face criminal prosecution or civil proceedings. All mileage is calculated by County software called NOVUS Med

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

Signature

Date



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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

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.

Signature

Date