DD Waiver Providers – Transportation Log

This form is intended for month end reporting of trips under 20 miles (one way). Please fax the completed log to the Transportation Center (800-291-7791) within 10 days of month end.

DD Provider Name: _____ Phone: _____ Provider # _____

Address: _____ City _____ Zip Code: _____

Client Name	Medicaid #	Appt. Date (mmddyy)	Appt. Time	Destination (Medical Provider Name and Address)	Covered Svc. (M.D., Dental, PT, etc.)	One-way Distance (Miles)	Medicaid Cov.(Y or N)

By signing below, provider certifies that all transportation requests are for travel to receive medically necessary services covered by the Medicaid program and in general by the least costly suitable means available.

_____ _____ _____

Name Title Date