828 1st Avenue East
Shakopee, MN 55379

Phone: (952) 496-8341
Fax: (952) 496-1842

Medical Assistance Contract Provider Trip Confirmation Form

This form must be completed and submitted to SmartLink Transit within 30 days of trip in order to receive payment.

CONFIDENTIAL: This fax contains patient identifiable information for use by the FAX receipient listed above. Disclosure of this information is prohibited by State and Federal Laws. If you have received this fax in error, please notify the sender immediately at the contact information above. Thank you.

PROVIDER NAME AND ADDRESS: ____

APPOINTMENT DATE: ____________________ APPOINTMENT TIME: ____________________

PICKUP ADDRESS: ____________________ DROP OFF ADDRESS: ____________________

____________________ ____________________

LAST NAME: ____________________ FIRST NAME: ____________________

CURB OR DOOR: ____________________ FARE COLLECTED: ____________________

OUTWARD LEG

BEGINNING ODOMETER: ____________________ ENDING ODOMETER: ____________________
SCHEDULED PU: ____________________am/pm ACTUAL PU: ____________________
ACTUAL DEPARTURE: ____________________am/pm APPT. ARRIVAL: ____________________
VIN NUMBER: ____________________ DRIV LIC NUMBER: ____________________
SIGNATURE____Member/Attendant/Facility/Client

RETURN LEG

BEGINNING ODOMETER: ____________________ ENDING ODOMETER: ____________________
SCHEDULED PU: ____________________am/pm ACTUAL PU: ____________________
ACTUAL DEPARTURE: ____________________am/pm APPT. ARRIVAL: ____________________
VIN NUMBER: ____________________ DRIV LIC NUMBER: ____________________
SIGNATURE____Member/Attendant/Facility/Client