|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Trip #1 | Trip Number (Call Alivi for this before your trip) |  | Appt. Date |  | Appt. Time |  | Type |  One-Way Roundtrip |
| Address where you were picked up Home Other |  | Medical Provider Phone  |  |
| Medical Provider Name |  | Medical Provider Address |  |
| I certify that this patient was seen for a Medicaid covered health service | Signature & Title of Healthcare Provider |  |
|  |
| Trip #2 | Trip Number (Call Alivi for this before your trip) |  | Appt. Date |  | Appt. Time |  | Type |  One-Way Roundtrip |
| Address where you were picked up Home Other |  | Medical Provider Phone  |  |
| Medical Provider Name |  | Medical Provider Address |  |
| I certify that this patient was seen for a Medicaid covered health service | Signature & Title of Healthcare Provider |  |
|  |
| Trip #3 | Trip Number (Call Alivi for this before your trip) |  | Appt. Date |  | Appt. Time |  | Type |  One-Way Roundtrip |
| Address where you were picked up Home Other |  | Medical Provider Phone  |  |
| Medical Provider Name |  | Medical Provider Address |  |
| I certify that this patient was seen for a Medicaid covered health service | Signature & Title of Healthcare Provider |  |
|  |
| Trip #4 | Trip Number (Call Alivi for this before your trip) |  | Appt. Date |  | Appt. Time |  | Type |  One-Way Roundtrip |
| Address where you were picked up Home Other |  | Medical Provider Phone  |  |
| Medical Provider Name |  | Medical Provider Address |  |
| I certify that this patient was seen for a Medicaid covered health service | Signature & Title of Healthcare Provider |  |

|  |  |
| --- | --- |
| I have completed this form, and I verify that the information on this trip log is true | Signature of Participant, Parent/Guardian, or Representative |
|  |

**This form can be faxed or emailed from the providers office to Alivi at 855-621-8962 or memberservices@alivi.com.**

**If you have any questions, please call Alivi.**