

Trip #1	Trip Number (Call Alivi for this before your trip)		Appt. Date		Appt. Time		Type	<input type="checkbox"/> One-Way <input type="checkbox"/> Roundtrip
	Address where you were picked up <input type="checkbox"/> Home <input type="checkbox"/> 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	<input type="checkbox"/> One-Way <input type="checkbox"/> Roundtrip
	Address where you were picked up <input type="checkbox"/> Home <input type="checkbox"/> 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	<input type="checkbox"/> One-Way <input type="checkbox"/> Roundtrip
	Address where you were picked up <input type="checkbox"/> Home <input type="checkbox"/> 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	<input type="checkbox"/> One-Way <input type="checkbox"/> Roundtrip
	Address where you were picked up <input type="checkbox"/> Home <input type="checkbox"/> 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 provider's office to Alivi at 855-621-8962 or memberservices@alivi.com.

If you have any questions, please call Alivi at the numbers below.

Alivi Reservation Line – Sunshine Health LTC/COMP	786-724-1976
Alivi Reservation Line – Sunshine Health LTC/COMP (Toll-Free)	888-863-0248
Alivi Reservation Line (Toll Free) – Sunshine Health MMA (Toll-Free)	844-352-0134
Alivi Reservation Line (Toll Free) – Sunshine Health Mindful Pathways (Toll-Free)	844-352-1485
Alivi Reservation Line (Toll Free) – Sunshine Health Pathway to Shine (Toll-Free)	844-352-0414
Alivi Reservation Line (Toll Free) – Sunshine Health Power to Thrive (Toll-Free)	888-588-9413



This information is available for free in other formats and languages. Please contact Member Services at 1-866-796-0530 (TTY 1-800-955-8770) Monday through Friday, 8 a.m. to 8 p.m.

Sunshine Health complies with applicable Federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, sex, pregnancy or sexual orientation. Sunshine Health provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact us at the number above. If you believe that Sunshine Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, pregnancy or sexual orientation, you can file a grievance with: 1557 Coordinator, P.O. Box 31384, Tampa, FL 33631, Phone: 1-833-236-9680 (TTY 711), Fax: 1-866-388-1769, Email: SM_Section1557Coord@centene.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://www.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TTY). Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>. This notice is available at Sunshine Health's website: SunshineHealth.com/non-discrimination.

Esta información está disponible en otros idiomas de manera gratuita. Comuníquese con nuestro número de servicio al cliente al 1-866-796-0530, TTY 1-800-955-8770 de lunes a viernes, de 8 a.m. a 8 p.m.

Si oumenm, oubyen yon moun w ap ede, gen kesyon nou ta renmen poze sou Sunshine Health, ou gen tout dwa pou w jwenn èd ak enfòmasyon nan lang manman w san sa pa koute w anyen. Pou w pale avèk yon entèprèt, sonnen nimewo 1-866-796-0530 (TTY 1-800-955-8770).

Ces informations sont disponibles gratuitement dans d'autres langues. Veuillez contacter les services aux membres au 1-866-796-0530, TTY 1-800-955-8770 du lundi au vendredi, de 8 heures à 20 heures.

Queste informazioni sono disponibili gratuitamente in altre lingue. Contattare il Servizio Membri al 1-866-796-0530, TTY 1-800-955-8770 dal lunedì al venerdì, dalle 8:00 alle 20:00

Эту информацию можно бесплатно получить на других языках. Обращайтесь в Отдел обслуживания по телефону 1-866-796-0530, телефону с текстовым дисплеем 1-800-955-8770 с понедельника по пятницу с 8:00 до 20:00.