Iowa Medicaid Meals and Lodging Claim Form

This form must be completed for each trip requiring meal and/or lodging reimbursement. Claim forms with incomplete information will not be reimbursed until all required information is received. Receipts are required for all meals and lodging expenses. Lodging information is only required when Member chooses to make their own lodging arrangements. Reimbursement amounts are specified in the Iowa Medicaid Meals and Lodging Reimbursement Policy.

Member/Trip Information

Medicaid ID #: _____

Member Name: _____

Phone: _____

Address: _____

City: _____

State, Zip: _____

Attendant Name: _____

Lodging Information

Lodging Trip #: _____

Start & End Date: _____

Lodging Name: _____

Phone: _____

Address: _____

City: _____

State, Zip: _____

Cost per night: _____

Medical Provider Information

Name: _____

Phone: _____

Address: _____

City: _____

State, Zip: _____

Meal Information

Meal Trip #:

	Count	Cost
Breakfast:		
Lunch:		
Dinner:		

Member Hospitalized? Yes ☐ No ☐ Period of Time? ___

Member Signature: _____ **Date:** _____

To be completed by Medical Provider or their staff:

By signing below, I verify that the Member's condition and/or treatment requires them (and attendant, if applicable) to incur additional meals and/or overnight lodging expenses.

Physician/Medical Provider Name: _____ Date: _____
(Print) (Signature)

Iowa Medicaid Provider # NPI: _____ Other: _____

I certify that the above-named member's medical conditions require an attendant to accompany them during their appointments.

_____
(Signature)

Please complete and return to: MTM Attention Meal Logs, 16 Hawk Ridge Circle, Lake St Louis, MO 63367, or Fax to: 844.299.6329 or Email to meallogs@mtm-inc.net. If you have questions, call (866) 572-7662 during normal business hours.