



Scheduled Date: ____/____/____
Scheduled Time: ____:____ ☐ AM ☐ PM

Trip Report Addendum

Member's Name:

Member Health First Colorado ID #:

Provider Name:

Health First Colorado Provider ID#:

Driver's Name:

Vehicle Plate #/VIN#:

Trip Information:

1. Actual Pick-up Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Pick-up Street Address	City	State	Zip Code
Actual Drop-off Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Drop-off Street Address	City	State	Zip Code

Pick-up Odometer

Drop-off Odometer

Mileage

2. Actual Pick-up Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Pick-up Street Address	City	State	Zip Code
Actual Drop-off Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Drop-off Street Address	City	State	Zip Code

Pick-up Odometer

Drop-off Odometer

Mileage

3. Actual Pick-up Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Pick-up Street Address	City	State	Zip Code
Actual Drop-off Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Drop-off Street Address	City	State	Zip Code

Pick-up Odometer

Drop-off Odometer

Mileage

Reasons for documentation discrepancies

I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both. I certify under penalty of perjury that I have obtained the information on the form from the patient or their representative, and the information provided is accurate to the best of my knowledge.

Treatment Location/Medical Facility:

Representative Name:

Representative Title:

Signature:

Date: