COLORADO
Department of Health Care Policy & Financing

Non-Emergent Medical Transportation Trip Report

Member Information:

Member's Name: _____ Member Health First Colorado ID #:_____

Did the Driver verify the member's identity? ◯ Yes ◯ No

Member's Signature: _____ Trip Date: _____

(Member, facility or escort may sign to confirm that trip occurred) Escort Name (if applicable): _____

Driver/Vehicle Information:

Driver's Name: _____Vehicle License Plate or VIN #:_____

Type of Vehicle: ◯ Ground Ambulance ◯ Wheelchair Van ◯ Stretcher Van ◯ Taxi ◯ Mobility/Ambulatory Vehicle

Trip Information: Type of Trip: ◯ ONE WAY ◯ ROUND TRIP

Date: _____ Actual Pick-up Time: _____ ◯ AM ◯ PM	Pickup Odometer Reading: _____	Pick-up Street Address, City, State, Zip
Actual Drop-Off Time: _____ ◯ AM ◯ PM	Destination Odometer Reading: _____	Dropoff Destination Street Address, City, State, Zip

Date: _____ Actual Pick-up Time: _____ ◯ AM ◯ PM	Pickup Odometer Reading: _____	Pick-up Street Address, City, State, Zip
Actual Drop-Off Time: _____ ◯ AM ◯ PM	Destination Odometer Reading: _____	Dropoff Destination Street Address, City, State, Zip