



Special Transportation Services (STS) Trip Form

This form is to be filled out by the STS driver for each trip and must be kept in the patient's file for up to 10 years by the STS provider. All of the fields in this form must be completed for this form to be valid. The completed information in this form is subject to audit by UCare representatives.

STS Provider Information

STS Provider Name		UCare Provider ID Number
Name of Driver	Vehicle ID Number	Vehicle License Number

Member and Transportation Information

Member Name	UCare Member ID Number	
Pick Up Address (including city, state, and zip code)	Pick Up Time	Odometer Reading (Start)
Drop Off Address (including city, state, and zip code)	Drop Off Time	Odometer Reading (End)
Member's Signature	Date	Total Mileage

Provider/Facility Information

Name of Provider/Facility		
Signature of Provider/Facility Staff Member <i>(I do hereby certify that the UCare member named above was brought in for an appointment at this facility today.)</i>	Your Title	Date

I certify that by signing this form, it is an accurate account of the miles I actually drove on the dates and at the times stated above.

Driver's Signature	Date
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