LogistiCare

LOGISTICARE EXPENSE REPORT

Must be sent to: LogistiCare Solutions- Attn: Facility Dept.

4832 E McDowell Rd, Suite 100
Phoenix, AZ 85008

Check should be made payable to:

NAME:_____

SOCIAL SECURITY#:_____

MAILING ADDRESS:_____

CITY/STATE/ZIP:_____

Medicaid Recipient Information:

NAME:_____

MEDICAID ID#:_____

NAME OF ATTENDANT:_____

LOGISTICARE AUTHORIZATION/JOB#:_____

Receipts for ALL expenses
must be INCLUDED with this Expense Report.

IMPORTANT: Form must be filled out completely in order to receive reimbursement. All receipts must be received no later than 30 days after the last appointment. Receipts received after the 30 day period will not be processed.

Date:							
	SUN	**MON**	**TUES**	**WED**	**THURS**	**FRI**	**SAT**
Breakfast							
Lunch							
Dinner							
Meals Total:							
Lodging							
Grand Total:							

Prepared by:_____

Approved by:_____

Total Amount: $