LogistiCare

# MISSOURI GAS MILEAGE REIMBURSEMENT TRIP LOG

**Must be sent to:** **LogistiCare Claims Department**
**2552 West Erie Drive Suite 101**
**Tempe, AZ 85282**

**DRIVER NAME:** _____ **RELATIONSHIP TO PARTICIPANT:** _____
**DRIVER MAILING ADDRESS:** _____ **DRIVER PHONE #:** _____
**CITY/STATE/ZIP:** _____
**PARTICIPANT NAME (If different from Driver)** _____ **PARTICIPANT MO HEALTHNET ID#:** _____

| Trip Date | Trip/Job # | Medical Provider Name & Phone # | Physician/Clinician Signature* | Total Miles |
|---|---|---|---|---|
| | | Name:<br>Phone #: | | |
| | | Name:<br>Phone #: | | |
| | | Name:<br>Phone #: | | |
| | | Name:<br>Phone #: | | |
| | | Name:<br>Phone #: | | |
| | | Name:<br>Phone #: | | |
| | | Name:<br>Phone #: | | |

*Each date of service must have a physician or clinician signature in order for reimbursement to be approved.
NOTE: Each trip will be confirmed with the physician's office before payments will be made

Do not write in this space.

Total mileage to be paid:_____ Total amount for this invoice:_____ Batch #: _____ Batch date:_____

**I hereby certify the information contained herein is true, correct and accurate. Signature** _____

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