MILEAGE REIMBURSEMENT TRIP LOG AND INVOICE FORM

Must be sent to: LogistiCare, Inc
Missouri NEMT Billing Department
503 Oak Place, Ste. 550
Atlanta, GA 30349

NAME: ____ RELATIONSHIP TO PARTICIPANT: ________________________

DRIVER MAILING ADDRESS: ____ DRIVER PHONE #:_________________________

CITY/STATE/ZIP: ____

PARTICIPANT NAME (If different from Driver): ______________________________ PARTICIPANT ID #:________________________

IS TRIP A STANDING ORDER? Y N IF YES, CIRCLE THE DAYS TRAVELED WEEKLY: S M T W T F S

Trip Date	Trip/Job #	Medical Provider Name & Phone #	Physician/Clinician Signature*	Total Miles
		Name: Phone #:		
		Name: Phone #:		
		Name: Phone #:		
		Name: Phone #:		
		Name: Phone #:		
		Name: Phone #:		

***Each date of service must have a clinical signature in order for reimbursement to be approved.**
NOTE: Each trip will be confirmed with the physician's office before payments will be made. This form must be received within 30 days of your appointment.

Do not write in this space.
Total mileage to be paid: ________________________ Total amount for this invoice: _____________________ Batch #: __________ Batch date: ______________

*****PLEASE FILL OUT A SEPARATE FORM FOR EACH PERSON TRANSPORTED*****

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

Revised 09/07