This Mileage Reimbursement form is to be used by any *AmeriHealth Caritas Louisiana* member who provided their own transportation to a non-emergency medical visit for a covered service.

It is mandatory that the physician sign the form for each visit and provide their phone number. Send the completed form to:

LogistiCare Claims Department
503 Oak Place, Suite 550
College Park, GA 30349

Prior to reimbursing the member, LogistiCare will call the physician to confirm the appointment.

AmeriHealth Caritas Louisiana

AmeriHealth Caritas Louisiana Gas Mileage Reimbursement Trip Log

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

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 #:		
		Name: 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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