LogistiCare

MILEAGE REIMBURSEMENT TRIP LOG AND INVOICE FORM

Must be sent to: **LogistiCare, Attn: Billing Dept, PO Box 248, Norton, VA 24273**

DRIVER NAME: _____ RELATIONSHIP TO MEMBER: _____

DRIVER MAILING ADDRESS: _____ DRIVER PHONE #: _____

CITY/STATE/ZIP: _____

MEMBER NAME (If different from Driver): _____ MEMBER 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 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.

Office Use Only: 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 _____