DIALYSIS MILEAGE REIMBURSEMENT LOG & INVOICE FORM

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

DRIVER NAME:_____ **DRIVER SSN:**_____

RELATIONSHIP TO PARTICIPANT:_____

PARTICIPANT NAME:_____ **PARTICIPANT ID:**_____
(If different from the Driver)

DRIVER MAILING ADDRESS:_____

CITY/STATE/ZIP CODE:_____

DRIVER PHONE #:__**(_____)**_____

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

Trip Date	Leg	MO HealthNet Provider Name	Total Miles	Clinical Signature*
	A	Name:		
	B	Name:		
	A	Name:		
	B	Name:		
	A	Name:		
	B	Name:		
	A	Name:		
	B	Name:		
	A	Name:		
	B	Name:		
	A	Name:		
	B	Name:		
	A	Name:		
	B	Name:		

*Each date of service must have a clinical signature in order for reimbursement to be approved. This form must be received within 45 days of your appointment.

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

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

Date:_____ **Driver's Signature:**_____