LogistiCare

DAILY TRIP LOG

Mail Invoices to:
LogistiCare Billing Dept.
503 Oak Place
Ste 503
Atlanta, GA 30349

KI BOIS Area Transit System - 9
Provider Name:

WEEK ENDING:

DRIVER'S NAME (as it appears on driver's license)

Vehicle Number (Last six of the VIN)

Date of Service	LogistiCare Job # A or B	Recipient's Name	A W S	Pick-up Time	Drop-off Time	Will-Call Time	Total Trip Mileage	Per Trip Billed Amount	Recipient's Signature

NOTE* **Leg of transport** - a leg of transport is the point of pick-up to the destination. Example: Picking recipient up at residence and transporting to the doctor's office would be considered one leg; picking the recipient up at the doctor's office and transporting back to the residence would be considered the second leg of the trip. Each leg of transport must be documented on separate lines. A signature is required for each leg of the transport. Pick-up and drop-off times **must** be documented **and** in military time.

Driver's Comments: _____

_____

I understand that LogistiCare, Inc. will verify the accuracy of the mileage being reported and I hereby certify the information herein is true, correct and accurate.

Driver's Signature: _____

A _____ **W** _____ **S** _____