LogistiCare Solutions, LLC

Gas Reimbursement Department
P.O. Box 464, North Haven, CT 06473
FAX (877) 457-3334
Affinity Health Plan – Reservation Line: 1-866-475-5749
AmeriChoice by UnitedHealthcare – Reservation Line: 1-866-913-2497

REQUEST FOR REIMBURSEMENT OF MEDICAL TRANSPORTATION BY PERSONAL CAR

REQUEST FOR APPROVAL TO BE COMPLETED BY ATTENDING PHYSICIAN/CLINICIAN	Medicaid Client ID #	Ins: DOB:
Patient Telephone No.	Name of Physician or Clinic Telephone No.	
Parent or Guardian of Child: Telephone No.	Address of Clinic	
Address of Member	City or Town of Clinic	
City or Town of Member with Zip Code	Services Rendered As: ❑ Att. Physician ❑ Consultant ❑ Other	
Diagnosis & General Physical Condition/Treatment:	Time of appointment(s):	

Circle days traveled if traveling on a monthly basis: ***S M T W T F S***	No. Visits: _____ (For entire month of pay period, do not document amount of days per week in this section)	www.bing.com/maps _____

Dates Service Given with Confirmation Numbers: (**Only** for Members who travel **less than 3 times a week**)

Dates Did Not Travel: (**Only** for Members who travel **3 or more times a week**)

Date	Physician/Clinician's Signature & Direct Phone Number (M**ust be legible)**	I hereby certify that the travel requested is necessary. **(Print Name Clearly)**

Office Use Only: Do not write below this line

_____TOTAL 1-WAY TRIP (S): _____

TOTAL AMOUNT: $ _____ *

Please don't forget to sign & date the forms; also do not sign the form earlier than the dates of service.

9/18/09