modivcare
FORMERLY LOGISTICARE

MILEAGE REIMBURSEMENT TRIP LOG

Must be sent to:
ModivCare Claims Department
798 Park Avenue NW
Norton, VA 24273

Driver name: ____ **Relationship to member:** ______________________________

Driver mailing address:_________________________________ **Driver phone #:**___________________________________

City/State/ZIP:______________________________________

Member name: _______________________________________ **Member Medicaid ID #:**____

Trip date	Trip/job confirmation #	Medical provider name and phone #	Physician/clinician signature*	Total miles
		Name: Phone #:		
		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.

I hereby certify the information contained herein is true, correct and accurate. Signature ____
(Member's signature)

Do not write in this space.
Total mileage to be paid:__________________________ Total amount for this invoice:_______________________ Batch #: ___________ Batch date:_______________