modivcare
FORMERLY LOGISTICARE

RHODE ISLAND MILEAGE REIMBURSEMENT TRIP LOG

Must be sent to: ModivCare Claims Department
798 Park Avenue NW, 4th Floor
Norton, VA 24273

DRIVER NAME: _____ **RELATIONSHIP TO MEMBER:** _____

DRIVER MAILING ADDRESS: _____ **DRIVER PHONE #:** _____

CITY/STATE/ZIP: _____

MEMBER NAME (If different from Driver): _____ **MEMBER ID #:** _____

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 #:		
		Name: Phone #:		

*Each date of service must have a physician or clinician signature in order for reimbursement to be approved. 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)