modivcare
FORMERLY LOGISTICARE

**SOUTH CAROLINA 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:<br><br>Phone #: | | |
| | | Name:<br><br>Phone #: | | |
| | | Name:<br><br>Phone #: | | |
| | | Name:<br><br>Phone #: | | |
| | | Name:<br><br>Phone #: | | |
| | | Name:<br><br>Phone #: | | |
| | | Name:<br><br>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)**