modivcare

North Carolina Mileage Reimbursement Trip Log

Must be sent to: Modivcare Claims Department
2552 W. Erie Dr, Suite 101
Tempe, AZ 85282

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: