modivcare

AmeriHealth Caritas North Carolina

AmeriHealth Caritas Mileage Reimbursement Trip Log

Mail claims 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 code:_____
Member name: _____ **Member Medicaid ID #:** _____

Trip date	Trip/job confirmation #	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/Authorized Representative Signature

Do not write in this space.

Total mileage to be paid: _____ Total amount for this invoice: _____ Batch #: _____ Batch date:_____