modivcare

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

DE Mileage Reimbursement Trip Log

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

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

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

*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.

Total Mileage to be paid:_____ Total amount for this invoice:_____ Batch #: _____ Batch Date:_____

Do not write in the above space

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