MILEAGE REIMBURSEMENT TRIP LOG

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

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: ____________