North Carolina Mileage Reimbursement Trip Log

Must be sent to:
ModivCareClaims Department
North Carolina Mileage Reimbursement
798 Park Ave NW, 4th Floor
Norton, VA 24273

Driver Name:_____ **Relationship to Member**:_____

Driver Mailing Address:_____ **Driver Phone**:_____

City/State/ZIP:_____

Member Name:_____ **Member Medicaid ID #**:_____

Trip Date	Job/Trip Confirmation #	Medical Provider Name and Phone Number	Physician/Clinician Signature*	Total Miles
		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:_____