Dear MO HealthNet participant,

We have enclosed a blank mileage reimbursement form with this letter. Feel free to make copies of the blank form for any future trips. You can also contact the Modivcare Reservation Line to request blank copies and trip /Job numbers.

Please note that your doctor/counselor must sign the form as proof that you were at the appointment. If your form is incomplete, you will not receive payment for your trip. The distance will be calculated as the number of miles from home to the medical appointment.

Here's how it works:

1. **When you call to schedule your trip you will receive a trip/job number. This trip number required on the reimbursement form. Write down the trip number and date of your trip on the reimbursement form as soon as you get it from the Modivcare reservation specialist. Forgetting to add this is a common mistake and will cause your reimbursement to be denied. Be sure to add the trip number to your form before you forget. You may schedule your trip in advance but no later than 5pm of the date of the appointment.**
2. **You must fill out the entire form except for the space for the Physician/Clinician Signature.**
3. **Take the form with you to your medical appointment and have your doctor or counselor sign it.**
4. **You can put up to seven trips on one form.**
5. **Please note that there can only be one driver on a form and Medicaid member.**
6. **The payment will be mailed within 30 days of the Modivcare Claims Department receiving your reimbursement form.**
7. **If you have any questions, issues or concerns, please call Modivcare Claims at 800-930-9060 Option 1 is Missouri.**

MISSOURI FACILTY 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 (If different from Driver):__________________________
MEMBER'S MEDICAID ID#:__________________

Trip Date	Trip/Job #	Medical Provider Name & Phone #	Physician/Clinician Signature*	Total Miles	Billed Amount
		Name: Medicaid ID#: Phone #:	Name: Signature:	________	
		Name: Medicaid ID#: Phone #:	Name: Signature:	________	
		Name: Medicaid ID#: Phone #:	Name: Signature:	________	
		Name: Medicaid ID#: Phone #:	Name: Signature:	________	
		Name: Medicaid ID#: Phone #:	Name: Signature:	________	
		Name: Medicaid ID#: Phone #:	Name: Signature:	________	

*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

Do not write in this space.
Total mileage to be paid:________________________ Total amount for this invoice:_____________________ Batch #: __________ Batch date:______________

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