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| **DRIVER INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Driver’s Name | | | | | | | | | | | Driver’s Address (Street) | | | | | | | | | | | | | | | | | | | |
| Driver’s License # | | | | | Driver’s License State | | | | | | City | | State | | | | | | | Zip Code | | | | | | | | | | |
| **SIGNATURE OF DRIVER** I confirm by, sending this log to agree I have a current, valid, and open driver's license; that the vehicle used to perform services has passed all state tests and is currently state registered and insured according to the laws and regulations of the state to which is registered. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **X** | | | | | | | | | | |  | | | | |  | | | | | | | | | | | | | | |
| **Signature** | | | | | | | | | |  | **Date** | | | | |  | | | | | | | | | | | | | | |
| **RECORD OF TRIPS** Each date of service must have a physician or clinician signature and will be reviewed with the physician's office before payments will be made. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Is Trip a Standing Order?** | | |  | Yes | |  | No | | **Standing Order Days of Traveled Weekly** | | | | |  | **S** | |  | | **M** | |  | **T** |  | **W** |  | **Th** |  | **F** |  | **S** | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Trip Date | Trip Number | Total Miles | | | | | Provider Name | | | | Provider Phone Number | | | | | | Physician / Clinician Signature | | | | | | | | | | | | |
| 1 |  |  |  | | | | |  | | | |  | | | | | |  | | | | | | | | | | | | |
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\*For California members: Per All Plan Letter 17-010 from the California Department of Health Care Services, Medi-Cal beneficiaries who drive themselves to their appointment are NOT eligible for mileage reimbursement.

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| --- | --- | --- | --- | --- |
| **MEMBER INFORMATION** | | | | |
| Relationship to Member | Member Name | | | Member ID |
| **SIGNATURE OF MEMBER** I hereby agree the above information is true and correct. I have also received, read and agreed to the gas reimbursement guidelines. | | | | |
| **X** | |  |  | |
| Member Signature | |  | Member Name (Print) | |

Completed forms can be sent to:

|  |  |  |
| --- | --- | --- |
| **Mail:** 798 Park Avenue NW, Norton, VA 24273 | **Fax:** 866-528-0462 | **Email:** Virginia.billingoperations@modivcare.com |

**Please allow 4-6 weeks for payment to be processed. For questions about your claim, call 1-800-930-9060.**