



## FL MILEAGE REIMBURSEMENT TRIP LOG AND INVOICE

### 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 driver log to agree I have a current, valid, and unrestricted 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 |           |             |             |               |                       |                                 |
| 2 |           |             |             |               |                       |                                 |
| 3 |           |             |             |               |                       |                                 |
| 4 |           |             |             |               |                       |                                 |
| 5 |           |             |             |               |                       |                                 |

### 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](mailto:Virginia.billingoperations@modivcare.com)

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



For Office Use Only

|                          |                      |              |            |
|--------------------------|----------------------|--------------|------------|
| Total mileage to be paid | Total invoice amount | Batch number | Batch date |
|--------------------------|----------------------|--------------|------------|