modivcare

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

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

aetna Community Care Plan The Health Plan with a Heart sunshine health Simply healthcare Humana United Healthcare CLEAR HEALTH ALLIANCE wellcare

For Office Use Only			
Total mileage to be paid	Total invoice amount	Batch number	Batch date