modivcare

Mileage Reimbursement Trip Log and Invoice Instructions

Dear beneficiary,

We have enclosed a blank reimbursement form with this letter along with instructions and a sample log for guidance. Feel free to make copies of the blank form for any future trips. You can also contact the ModivCare Reservation Line as well as visit ModivCare.com to obtain additional blank copies of the form.

Below outlines how to be reimbursed for mileage:

1. When you call to schedule your trip, you will receive a trip number. This trip number is 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 it to your form before you forget!

   If you are a Medi-Cal beneficiary with insurance through a managed care organization, please be advised that per All Plan Letter 17-010 from the California Department of Health Care Services, a Medi-Cal beneficiary who drives themselves to their appointment is NOT eligible for mileage reimbursement.

2. You must fill out the entire form except for the space for "Physician/Clinician Signature".

3. Take the form with you to your medical appointment and have your doctor or counselor sign it. Your doctor or counselor should sign in the "Physician/Clinician Signature" space on the form. **Please note that your doctor/counselor must sign the form as proof that you were at your appointment.**

4. You can put multiple trips on one form.

5. Please note that there can only be one driver on a form. You must complete and send a separate form for each of the people driving you to your medical appointments.

6. Once your form is complete, please send your form via mail, email, or fax.

   Mail: 798 Park Avenue NW, Norton, VA 24273

   Email: support.claims@modivcare.com

   Fax: 866-528-0462

7. The request for reimbursement is required on or before the day of the medical appointment, and the voucher must be received within 30 days, or it may be denied. If you are listing more than one appointment, you must submit the completed form within 30 days from the earliest appointment shown.

8. Payment will be mailed within thirty (30) business days of the ModivCare Claims Department receiving your completed reimbursement form.

If you have any questions, please call ModivCare Claims Department at 1-800-930-9060.

Thank you,

Modivcare

Guidelines for Completing the Mileage Reimbursement Trip Log

Below we provide guidelines for completing the Mileage Reimbursement Trip Log. Please adhere to the guidelines provided. **Failure to do so may result in denial of payment.**

1. Please print all required information clearly, leaving enough space between words for legibility.
2. Avoid using any special characters, symbols, or non-Latin script (e.g., #, @, $, ~).
3. Do not write on top of or above the title sections of the form.
4. If an error is made, replace the form with a new one. Do not cross out, highlight, or annotate the form.
5. When submitting the form, ensure a high-quality image is provided with limited distortions or distractions. The image should primarily focus on the form.
6. Fill out the entire form and provide all the required information.
7. Avoid using abbreviations or acronyms.
8. Ensure that the form's text is oriented correctly and is not upside down or sideways.
9. Use black or dark blue ink when filling out the form.
10. Do not use different fonts or font sizes within the form.

ITP Gas Reimbursement (Claim Form Example)

ID can be found on Medicaid card

Client Name:	Client Telephone:	Client Medicaid:
John Doe	(123) 456-789	000111222
ITP Name (Must match Driver's License)	**ITP Telephone:**	**ITP MTI Number:**
James Jones Smith	(987) 654-321	333444555

Driver's name assigned to trips

Driver's license number

Trip #1

From:	To:	Miles:	Amount:
1234 Main St.	8910 Broadway	10	20
From:	**To:**	**Miles:**	**Amount:**
8910 Broadway	1234 Main St.	10	20
Authorization Number:	**Appointment Date:**	**Total Miles:**	**Total Amount:**
12345	02/28/2023	20	40
Health Care Provider NPI:	**Health Care Provider Telephone:**	**Health Care Provider Name:**	
9876543211	(555)123-456	General Hospital	

This number is provided at the time of reservation with Modivcare.

Number can be collected from Healthcare Provider

I c vas seen for a Medicaid/ CS are service.	Signature & Title of Health-care Provider:	Date Signed:
	Dr. Jane Johnson	03/01/2023

Trip #2

From:	To:	Miles:	Amount:
From:	**To:**	**Miles:**	**Amount:**
Authorization Number:	**Appointment Date:**	**Total Miles:**	**Total Amount:**
Health Care Provider NPI:	**Health Care Provider Telephone:**	**Health Care Provider Name:**	
	( )		

I certify that this patient was seen for a Medicaid/ CSHCN covered health-care service.	Signature & Title of Health-care Provider:	Date Signed:

ITP Drivers: *Please note that the allowable mileage that may be claimed for reimbursement is preprinted on the form.*

AFFIDAVIT: This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim is from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws. I hereby certify that this claim contains no willful misrepresentation or falsification and that the information I have given is true and correct to the best of my knowledge and belief. **I attest that I have complied with all of the provisions of the Individual Transportation Participant Agreement when providing the transportation services for which I am seeking reimbursement.**

James Jones Smith

Signature of Individual Transportation Participant (ITP)

03.01.2023

Date

Claim form must be mailed to Modivcare

ATTN: Claims 798 Park Ave NW 4th Floor Norton, VA 24273

Emailed to: support.claims@modivcare.com

Faxed to: 866-528-0462

Note: *Please retain a copy for your records*

modivcare

ITP Gas Reimbursement (Claim Form)

Client Name:	Client Telephone:	Client Medicaid:
	( )	
ITP Name (Must match Driver's License)	**ITP Telephone:**	**ITP MTI Number:**
	( )	

Trip #1

From:	To:	Miles:	Amount:
From:	**To:**	**Miles:**	**Amount:**
Authorization Number:	**Appointment Date:**	**Total Miles:**	**Total Amount:**
Health Care Provider NPI:	**Health Care Provider Telephone:**	**Health Care Provider Name:**	
	( )		
I certify that this patient was seen for a Medicaid/ CSHCN covered health-care service.	**Signature & Title of Health-care Provider:**	**Date Signed:**	

Trip #2

From:	To:	Miles:	Amount:
From:	**To:**	**Miles:**	**Amount:**
Authorization Number:	**Appointment Date:**	**Total Miles:**	**Total Amount:**
Health Care Provider NPI:	**Health Care Provider Telephone:**	**Health Care Provider Name:**	
	( )		
I certify that this patient was seen for a Medicaid/ CSHCN covered health-care service.	**Signature & Title of Health-care Provider:**	**Date Signed:**	

ITP Drivers: ***Please note that the allowable mileage that may be claimed for reimbursement is preprinted on the form.***

AFFIDAVIT: This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim is from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws. I hereby certify that this claim contains no willful misrepresentation or falsification and that the information I have given is true and correct to the best of my knowledge and belief. **I attest that I have complied with all of the provisions of the Individual Transportation Participant Agreement when providing the transportation services for which I am seeking reimbursement.**

Signature of Individual Transportation Participant (ITP)

Date

Claim form must be mailed to Modivcare

ATTN: Claims 798 Park Ave NW 4th Floor Norton, VA 24273

Emailed to: support.claims@modivcare.com

Faxed to: 866-528-0462

Note: ***Please retain a copy for your records***