modivcare

NEW JERSEY GAS MILEAGE ATTENDANCE VERIFICATION LOG

Must be sent with mileage log to:
Modivcare Claims Department
798 Park Avenue NW, 4th Floor
Norton, VA 24273

MEMBER NAME (If different from Driver): _____ **MEMBER ID#:** _____

Trip Date	Trip/Job #	Medical Provider Name & Phone #	Facility Signature*
		Name: Phone #:	
		Name: Phone #:	
		Name: Phone #:	
		Name: Phone #:	
		Name: Phone #:	
		Name: Phone #:	
		Name: Phone #:	

*Each date of service must have a physician or clinician signature in order for reimbursement to be approved. The facility signature is a confirmation of the member's attendance only and not a verification of the identity of the driver.

NOTE: Each trip will be confirmed with the physician's office before payments will be made.

I hereby certify the information contained herein is true, correct and accurate. Signature: _____