modivcare

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 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 _____ _____

Driver 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						

*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.

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:** support.claims@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