



MILEAGE REIMBURSEMENT TRIP LOG AND INVOICE
 Mail to: LogisticCare, 798 Park Avenue NW, Norton, VA 24273
 Phone: 866-907-5186

DRIVER NAME: _____ RELATIONSHIP TO MEMBER: _____
 DRIVER MAILING ADDRESS: _____ DRIVER PHONE #: _____
 CITY/STATE/ZIP: _____ DRIVER'S LICENSE # _____

MEMBER ID #: _____ I, _____, by submitting this driver log do affirmatively certify I have a current, valid and unrestricted Virginia driver's license; that the vehicle used to perform the services has passed an annual inspection by the Commonwealth of Virginia and that the vehicle is currently and properly registered and insured pursuant to the laws and regulations of the Commonwealth of Virginia

IS TRIP A STANDING ORDER? Y N IF YES, CIRCLE THE DAYS TRAVELED WEEKLY: S M T W T F S

Trip Date	Trip/Job #	Provider Name & Phone #	Physician/Clinician Signature*	Total Miles
		Name: Phone #:		

*Each date of service must have a physician or clinician signature in order for reimbursement to be approved.
 NOTE: Each trip will be confirmed with the physician's office before payments will be made.
 Do not write in this space: _____ Total amount for this invoice: _____ Batch #: _____ Batch date: _____
 Total mileage to be paid: _____

****PLEASE FILL OUT A SEPARATE FORM FOR EACH PERSON TRANSPORTED**** ***All appointments need to be Scheduled before the trip / appointment occurs***
 I hereby certify the information contained herein is true, correct and accurate. I have also received, read and agreed to the gas reimbursement guidelines.
 Member Name (Please Print): _____ Member Signature: _____