

# LogistiCare<sup>®</sup>

## NOTICE:

Effective immediately, the LogistiCare  
Norton Offices have an address change:

Please send all future correspondence  
to:

LogistiCare Solutions  
798 Park Ave NW, 4<sup>th</sup> Floor  
Norton, VA 24273

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## VIRGINIA MILEAGE REIMBURSEMENT PROCEDURE

Scheduling transportation and being reimbursed through LogistiCare's Mileage Reimbursement Program is easy! The Medicaid member, a friend, a neighbor or relative will be reimbursed for street or road mileage from a member's residence to the service site and the return trip.

The member or member's responsible party will need to call 866-386-8331 to schedule transportation for mileage reimbursement prior to the appointment. When scheduling mileage reimbursement trips, the member will need the physical address, telephone number and name of the treating physician or facility at which he/she has the appointment. Additionally the member will need the name, mailing address and telephone number of the person who will be driving (A customer service representative will need this information when scheduling the mileage reimbursement trip). The member will need to document the reference number that is given at the completion of the call. Mileage reimbursement trip logs will be mailed to the member. The member should notify the customer service representative when additional mileage reimbursement trip logs are needed.

In order for the driver to be reimbursed, he/she will need to complete the following information on the mileage reimbursement trip logs:

- Driver Name—name of person driving
- Driver Mailing Address— address, city, state and zip code (this is where the mileage reimbursement check will be mailed)
- Driver Relationship to Member—Example: friend, neighbor or relative
- Driver Telephone Number—telephone number of the person driving
- Driver's License Number —license number of the driver
- Driver Signature—driver must sign the statement on the form certifying that all requirements (driver and vehicle) meet the laws and regulations of the Commonwealth of Virginia
- Member Name—name of the Medicaid Member
- Member's Medicaid Number—member's ID number as it appears on his/her Medicaid card
- Circle Yes or No as to whether or not this is a standing order appointment. If yes, circle the days traveled weekly
- Trip Date—document the date of the appointment
- Trip/Job Number — document the reference number given when scheduling the mileage reimbursement trip request
- Facility/Medical Provider Name & Phone No.—document the name and phone number of the treating facility/doctor the member is scheduled to see.
- Physician/Clinician Signature—have the physician's office sign to verify attendance
- Total Miles—document the total miles of the trip from the Medicaid member's residence directly to the facility/doctor's office. The shortest distance will be

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verified and paid. (The mileage from the driver's residence to and from the Medicaid member's residence will not be reimbursed)

- Signature—at the bottom of the mileage reimbursement trip log, the driver must sign their name, certifying that the information is true, correct and accurate
- Mail completed mileage reimbursement trip log(s) to the address listed on top of the log (LogistiCare Mileage Reimbursement, 798 Park Avenue NW, Norton, VA 24273)

Once LogistiCare has received the mileage reimbursement trip log(s), all documented information will be verified by the Claims Department. After the completion of the verification process, payments will be issued. Payments will be mailed within 30 days from the date the mileage reimbursement trip log is received by the Claims department.

If the mileage reimbursement trip log is not submitted properly the request will be denied. Notification will be sent explaining the reason for the denial. Corrected mileage reimbursement trip logs can be resubmitted for payment.

If there is disagreement with the action taken, the driver may file for an appeal. A request for an appeal must be submitted in writing within 30 days of receipt of LogistiCare's notice of denial. The appellant may write a letter or complete the enclosed Appeal Request Form.

A copy of the denial notice should be included with the appeal request.

Mail the completed and signed appeal request form to:

**Appeals Division  
Department of Medical Assistance Services  
600 E. Broad Street  
Richmond, Virginia 23219  
Appeal requests may also be faxed to:  
(804) 371-8491**

Please call LogistiCare at 866-386-8331 if there are any questions.



**MILEAGE REIMBURSEMENT TRIP LOG AND INVOICE**  
 Mail to: LogistiCare, 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, 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 mileage to be paid: \_\_\_\_\_ Total amount for this invoice: \_\_\_\_\_ Batch #: \_\_\_\_\_ Batch date: \_\_\_\_\_

**\*\*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: \_\_\_\_\_