LogistiCare

MILEAGE REIMBURSEMENT TRIP LOG AND INVOICE

Mail to: LogistiCare, 798 Park Ave, NW, Norton, VA 24273
Phone: 866-907-5186
Fax: 866-528-0462

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 #:		
		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.**
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: _____

Jan 2016