# MILEAGE REIMBURSEMENT TRIP LOG AND INVOICE FORM

LogistiCare

Send to: ATTN: Colorado Gas Reimbursement

**4832 E McDowell Rd; Ste. 100**
**Phoenix, AZ 85008**
**Phone: 866-418-9830**

DRIVER NAME: _____ RELATIONSHIP TO MEMBER: _____

DRIVER MAILING ADDRESS: _____ DRIVER PHONE #: _____

CITY/STATE/ZIP: _____ DRIVER'S LICENSE # _____

DRIVER'S INSURANCE POLICY # _____ ***** PLEASE ATTACH A COPY OF DRIVER LICENSE AND INSURANCE CARD *****

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

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 # | Medical Provider Name & Phone # | Physician/Clinician Signature* | Total Miles |
|---|---|---|---|---|
| | | Name:<br><br>Phone #: | | |
| | | Name:<br><br>Phone #: | | |
| | | Name:<br><br>Phone #: | | |
| | | Name:<br><br>Phone #: | | |
| | | Name:<br><br>Phone #: | | |
| | | Name:<br><br>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.

**Signature** _____

Forms must be received no later than 30 days from first shown appointment or will be denied for payment.