LOUISIANA MILEAGE REIMBURSEMENT TRIP LOG

Must be sent to: **LogistiCare Claims Department**
2552 West Erie Drive, Suite 101
Tempe, AZ 85282-3100

DRIVER NAME: ______________________________ **RELATIONSHIP TO MEMBER:** ______________________________

DRIVER MAILING ADDRESS:______________________ **DRIVER PHONE #:**______________________________

CITY/STATE/ZIP:______________________

MEMBER NAME (If different from Driver):__________________________________ **MEMBER ID#:**________________

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

I hereby certify the information contained herein is true, correct and accurate. Signature ____

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