LogistiCare

MILEAGE REIMBURSEMENT TRIP LOG AND INVOICE FORM

Mail to: Logisticare Attn. Claims Department
503 Oak Place Suite 550
Atlanta, GA 30349

DRIVER NAME: _____ RELATIONSHIP TO MEMBER: _____

DRIVER MAILING ADDRESS: _____ DRIVER PHONE #:_____

CITY/STATE/ZIP: _____

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: Phone #:		
		Name: Phone #:		
		Name: Phone #:		
		Name: Phone #:		
		Name: Phone #:		
		Name: Phone #:		

***Each date of service must have an authorized signature in order for reimbursement to be approved.**
NOTE: Each trip will be confirmed with the physician's office before payments will be made.

Total mileage to be paid:_____ Total amount for this invoice:_____ Batch #: _____ Batch date:_____