UHC CIP MILEAGE REIMBURSEMENT TRIP LOG

Must be sent to: LogistiCare Claims Department
12234 N. IH 35, Bldg B, Ste 175
Austin, TX 78753

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 (the CIP member) hereby certify the information contained herein is true, correct and accurate. Signature ______________________________________

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