LogistiCare

MILEAGE REIMBURSEMENT FORM – Texas

Send to: Logisticare Arizona/ Billing Department
4832 E McDowell Road,, Suite 100
Phoenix, Arizona 85008

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

THIS VOUCHER MUST BE SENT IN WITHIN 30 DAYS OF YOUR APPOINTMENT OR PAYMENT WILL BE DENIED

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

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

Logisticare Billing Department: 1-866-418-9830 ext 2221 for claims questions, ext 2225 for claims Lead, and ext 2011 for claims Manager

*****PLEASE FILL OUT A SEPARATE FORM FOR EACH PERSON TRANSPORTED*****

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 _____