LogistiCare

Texas Gas Reimbursements
www.logisticare.com

Dear Texas Gas Reimbursement Member,

We enclosed a blank voucher with this letter. You can make as many copies as you need. **Your doctor/counselor must sign the voucher to show you were at your appointment in order for your driver to get paid.**

Here's how it works:

1. When you call in a trip in advance, you will be given a job/trip number.

2. Please confirm with the reservation specialist the person that will be reimbursed is correct. This includes the name and address of the payee.

3. Write the job/trip number and the trip date on the Voucher.

4. Fill in all of the other blanks **except** the Physician/Clinician Signature space.

5. Take the Voucher with you and have the doctor or counselor sign it.

6. If you go more than once a month you can put several trips on one form.

7. **Only the person designated as the person to be paid when your reservation was set-up will be paid. If you have different people being paid you must submit a separate form for each person.**

8. Mail the signed form to:

   LogistiCare Claims Department
   Texas Gas Reimbursements
   12234 N Interstate 35
   Building B – Suite 175
   Austin, Texas 78753-1705

9. Voucher must be received within 30 days of the appointment or they may be denied.

10. Checks are mailed according to the scheduled attached:
    Reimbursement rate is 40¢ (cents) per mile.

If you have any questions or concerns please call 1-877-564-9837.

LogistiCare

Non-Emergency Medical Transportation Program
Driver Claim Form

Send to: LogistiCare Texas Claims
12234 N Interstate 35
Building B - Suite 175
Austin, TX 78753
For claim questions call: 877-564-9837

DRIVER'S NAME_____ **DRIVER'S PHONE #**_____

DRIVER'S MAILING ADDRESS:_____ **CITY/STATE/ZIP:**_____

RIDER'S NAME (If different from Driver): _____ **RIDER'S MEDICAID I.D. #** _____

RIDER'S DATE OF BIRTH: _____ **RIDER'S PHONE #:** _____

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 a physician or clinician signature in order for reimbursement to be approved.**

AFFIDAVIT: This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim is from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws. I hereby certify that this claim contains no willful misrepresentation or falsification and that the information I have given is true and correct to the best of my knowledge and belief. I further attest that the vehicle used in the transportation of Medicaid riders has a current registration and state safety inspection.

DRIVER'S SIGNATURE: _____ **DATE:** _____