modivcare
FORMERLY LOGISTICARE

DE Mileage Reimbursement Trip Log

Must be sent to: Modivcare Claims Department

798 Park Avenue NW

Norton, VA 24273

DRIVER NAME: _____ **RELATIONSHIP TO DRIVER:**_____

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

*Each date of service must have a physician or clinician signature in order for reimbursement to be approved. 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: _____

Do not write in the above space

I hereby certify the information contained herein is true, correct and accurate. Signature _____ **(member's signature)**