



# FL MILEAGE REIMBURSEMENT TRIP LOG AND INVOICE INSTRUCTIONS

## DRIVER INFORMATION

Driver's Name <b>John Doe</b>		Driver's Address (Street) <b>1234 Main St.</b>		
Driver's License # <b>ABC123</b>	Driver's License State <b>CO</b>	City <b>Anywhere</b>	State <b>CO</b>	Zip Code <b>12345</b>

## SIGNATURE OF DRIVER

I confirm by sending this driver log to agree I have a current, valid, and unrestricted driver's license; that the vehicle used to perform services has passed all state tests and is currently state registered and insured according to the laws and regulations of the state to which is registered.

*X John Doe*

**06/15/2022**

Signature

Date

Select yes if trips are recurring.

Select each day the trip reoccurs, if applicable.

## RECORD OF TRIPS

Each date of service must have a physician or clinician signature and will be reviewed with the physician's office before payments will be made.

Is Trip a Standing Order?  Yes  No Standing Order Days Traveled Weekly  S  M  T  W  Th  F  S

Trip Date	Trip Number	Total Miles	Provider Name	Provider Phone Number	Physician / Clinician Signature
01/01/2022	12564	15	Dr. Jane Smith	123-555-5555	Jane Smith, MD
2	This number is provided at the time of reservation with Modivcare.				
3					
4					
5					

ID can be found on members health insurance card

## MEMBER INFORMATION

Relationship to Member <b>Spouse</b>	Member Name <b>Jane Doe</b>	Member ID <b>987654321</b>
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## SIGNATURE OF MEMBER

I hereby agree the above information is true and correct. I have also received, read and agreed to the gas reimbursement guidelines.

*X Jane Doe*

**Jane Doe**

Member Signature

Member Name (Print)

Completed forms can be submitted to:

**Mail: 798 Park Avenue NW, Norton, VA 24273**

**Fax: 866-528-0462**

**Email: [support.claims@modivcare.com](mailto:support.claims@modivcare.com)**

**For questions about your claim, call 1-800-930-9060.**

