PacificSource Community Solutions

modivcare

MILEAGE REIMBURSEMENT TRIP LOG AND INVOICE FORM

ModivCare
Claims Department: 1-800-930-9060
Fax: 866-528-0462
Email: support.claims@modivcare.com

Mail completed form to:
ModivCare - Attn: Claims
798 Park Ave NW
Norton, VA 24273

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

DRIVER NAME: _____

RELATIONSHIP TO MEMBER: _____

DRIVER MAILING ADDRESS: _____

DRIVER PHONE NUMBER: _____

DRIVER CITY/STATE/ZIP: _____

PACIFICSOURCE MEMBER ID NUMBER: _____

MEMBER NAME (if different from driver): _____

MEMBER HOME ADDRESS (City/State/Zip): _____

Usted puede recibir este documento en otro idioma, impreso en una letra más grande o de otra manera que sea mejor para usted. También puede solicitar un intérprete. Esta ayuda es sin costo. Llame al 800-431-4135 o por TTY al 711. Aceptamos llamadas del servicio de retransmisión.

You can get this document in another language, large print, or another way that's best for you. You can also request an interpreter. This help is free. Call 800-431-4135 or TTY 711. We accept all relay calls.

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The voucher must be received within 45 days or it may be denied. If you are putting more than one appointment, you must submit the completed form within 45 days from the earliest appointment shown.

Trip date	Trip/job confirmation number	Medical provider name and phone number	One-way or Round Trip	Reason for Appointment	Physician/clinician signature*
		Name: Phone number:	Check one: One-way Round Trip		
		Name: Phone number:	Check one: One-way Round Trip		
		Name: Phone number:	Check one: One-way Round Trip		
		Name: Phone number:	Check one: One-way Round Trip		

*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.

I hereby certify the information contained herein is true, correct and accurate.

Signature _____
(Member's Signature)

Do not write in this space.

Total mileage to be paid: _____ Total amount for this invoice:

Batch #: _____ Batch date: _____