Mileage Reimbursement Trip Log

www.LogistiCare.com

Must be mailed to: LogistiCare Claims Department
2552 West Erie Drive, Suite 101
Tempe, AZ 85282-3100
Phone: (877)564-5665

MEMBER NAME:_____ **MEMBER ID#:**_____

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

DRIVER MAILING ADDRESS:_____ **DRIVER PHONE #:**_____

CITY/STATE/ZIP:_____

Trip Date	Trip #	Miles of Trip	Physician Name	Physician Phone	Physician Signature*
					X.
					X.
					X.
					X.
					X.
					X.
					X.

*** You must have a physician signature on each date of service for payments to be made.**
NOTE: Each trip will be confirmed with the physician's office.

Do not write in this space.

Total mileage to be paid:_____ Total amount for this invoice:_____ Batch #: _____ Batch date:_____

The information contained here is true and accurate. ***Signature:*** _____