modivcare

# MILEAGE REIMBURSEMENT TRIP LOG AND INVOICE

**DRIVER INFORMATION**

| Driver's Name | | Driver's Address (Street) | | |
|---|---|---|---|---|
| Driver's License # | Driver's License State | City | State | Zip Code |

**SIGNATURE OF DRIVER**

I confirm by, sending this log to agree I have current auto insurance; I have a valid state license; the vehicle used to perform services has passed all state tests; I have not been found guilty of felony of controlled substances; I have not been found guilty of more than two moving violations, operating while intoxicated, and/or driving under the influence within the past two years.

**X** _____ _____

***Signature** **Date**

*For Michigan drivers, by signing above, you agree that you are not currently excluded from participating from any federal health care program or listed on the MDHHS sanctioned provider list or U.S. Department of Health and Human Services exclusion list.

**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 of Traveled Weekly** ☐ **S** ☐ **M** ☐ **T** ☐ **W** ☐ **Th** ☐ **F** ☐ **S**

| | Trip Date | Trip Number | Total Miles | Provider Name | Provider Phone Number | Physician / Clinician Signature |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |

*For California members: Per All Plan Letter 17-010 from the California Department of Health Care Services, Medi-Cal beneficiaries who drive themselves to their appointment are NOT eligible for mileage reimbursement.

**MEMBER INFORMATION**

| Relationship to Member | Member Name | Member ID |
|---|---|---|
| | | |

**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** _____ _____

Member Signature Member Name (Print)

Completed forms can be sent to:

**Mail:** 798 Park Avenue NW, Norton, VA 24273 **Fax:** 866-528-0462 **Email:** support.claims@modivcare.com

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