LogistiCare

Mail To:
LogistiCare Claims Department
1640 Phoenix Blvd., Suite 110
College Park, GA 30349

MILEAGE REIMBURSEMENT TRIP LOG

Driver name: _____ Member name (if different from driver):_____
Driver mailing address: _____ Member ID# _____
City: _____State: _____ Zip Code: _____ Drivers relationship to member:_____
Driver phone#: ( )

TRIP DATE	LOGISTICARE CONFIRMATION #	MEDICAL PROVIDER NAME AND PHONE	PHYSICIAN/CLINICIAN SIGNATURE	TOTAL MILES
		Name: Phone:		
		Name: Phone:		
		Name: Phone:		
		Name: Phone:		
		Name: Phone:		
		Name: Phone: Phone: Phone:		

*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

_____Official use, do not write below this line_____

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

"Caution: This information contains confidential and proprietary trade secrets, the release of which could cause competitive harm. It is not subject to disclosure under any freedom of information act or open records act law or regulation. Do not further disclose."