LogistiCare

Mail To:
LogistiCare Claims Department
798 Park Avenue NW, 4th Floor
Norton, VA 24273
or fax to: **866-528-0462**

MAINE 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#: ( )

Drivers License# _____ I, _____ By Submitting this driver log do affirmatively certify I have a current and valid unrestricted Maine driver's license; that the vehicle used to perform the service listed below has a current and valid annual vehicle inspection sticker issued by the state of Maine and is currently and properly registered and insured pursuant to the laws and regulation of the state of Maine.

I hereby certify the information contained herein is true, correct and accurate. _____ (Driver)

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:		
		Name: 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. The mileage reimbursement rate for MaineCare members is .21 cents per loaded mile. This form must be submitted no later than 60 days past the first appointment or reimbursement will be denied

_____Official use, do not write below this line_____

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