LogistiCare

NEVADA MILEAGE REIMBURSEMENT TRIP LOG

Must be sent to: **LogistiCare Claims Department**
2552 West Erie Drive Suite 101
Tempe, AZ 85282-3100
Fax – 1-877-316-2599

DRIVER NAME: _____ **RELATIONSHIP TO PARTICIPANT:** _____
DRIVER MAILING ADDRESS: _____ **DRIVER PHONE #:** _____
CITY/STATE/ZIP: _____
MEMBER NAME (If different from Driver) _____ **MEMBER MEDICAID ID#:** _____

Trip Date	Trip/Job #	Medical Provider Name & 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 or a receipt from the doctor's office, pharmacy slip or discharge papers for reimbursement to be approved.

Do not write in this space.

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

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

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