LogistiCare

Send to: **LogistiCare Claims Department**
IL Mileage Reimbursement
2552 West Erie Drive, Suite 101
Tempe, AZ 85282-3100

IL Mileage Reimbursement Trip Log

Version 1 - 2018

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

DRIVER MAILING ADDRESS: _____

CITY/STATE/ZIP: _____ **DRIVER PHONE #:** _____

MEMBER NAME (If different from Driver): _____ **MEMBER ID#:** _____

IS THIS TRIP A STANDING ORDER? YES NO **IF YES, CIRCLE THE DAYS TRAVELED WEEKLY: S M T W T F S**

Trip Date	Trip/Reservation #	Medical Provider Name & Phone #	Physician/Clinician Signature*	Total Miles
		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.**
Each trip will be confirmed with the physician's office before payments will be made.

****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.

Member Signature: _____ **Date:** _____