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:** __________________