modivcare™
FORMERLY LOGISTICARE

MICHIGAN GAS MILEAGE REIMBURSEMENT TRIP LOG

Must be sent to:
ModivCare Claims Department
2552 West Erie Drive Suite 101
Tempe, AZ 85282

DRIVER NAME: _____RELATIONSHIP TO MEMBER: _____

DRIVER MAILING ADDRESS: _____CITY/STATE/ZIP: _____

DRIVER PHONE #:_____

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

* **Your health care professional must sign this voucher to show you were at your appointment in order for your driver to get paid.**
. NOTE: 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. Driver Signature _____

<u>Please call your reservation number if you need a trip/job # or if you need to change anything about a trip.</u>
Only the person designated as the driver when your reservation is made will be paid. If you have different drivers you must submit a separate form for each driver. Please allow 28 days from the date you mail trip logs before calling about payment status.