MILEAGE REIMBURSEMENT FORM

Send to: Logisticare Arizona/ Billing Department
4832 E McDowell Road,, Suite 100
Phoenix, Arizona 82008

DRIVER NAME: ______________________________ RELATIONSHIP TO MEMBER: ________________________

DRIVER MAILING ADDRESS: __________________________________ DRIVER PHONE #:____________________

CITY/STATE/ZIP: __________________________________

MEMBER NAME (If different from Driver): __________________________ MEMBER ID #: ____________________

IS TRIP A STANDING ORDER? Y N IF YES, CIRCLE THE DAYS TRAVELED WEEKLY: S M T W T F S

THIS FORM MUST BE SENT IN WITHIN 30 DAYS OF YOUR APPOINTMENT OR PAYMENT WILL BE DENIED

Trip Date	Trip/Job #	Medical Provider Name & Phone #	Physician/Clinician Signature*	Total Miles
		Name: Phone #:		
		Name: Phone #:		
		Name: Phone #:		
		Name: Phone #:		
		Name: Phone #:		

***Each date of service must have a physician or clinician signature in order for payment to be approved.**
NOTE: Each trip will be confirmed with the physician's office before payments will be made.

*****PLEASE FILL OUT A SEPARATE FORM FOR EACH PERSON TRANSPORTED*****

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