LogistiCare

PACIFICSOURCE COMMUNITY SOLUTIONS MILEAGE REIMBURSEMENT TRIP LOG

Must be sent to: **LogistiCare Claims Department**
2552 West Erie Drive, Suite 101
Tempe, AZ 85282-3100
Phone: (877)564-5665
Fax: (866) 420-6297

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

DRIVER MAILING ADDRESS: _____ **DRIVER PHONE #:** _____

CITY/STATE/ZIP: _____

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

Trip Date	**Trip #**	**Medical Provider Name & Phone #**	**To Address**	**From Address**	Physician/Clinician Signature*
		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 in order for reimbursement to be approved. NOTE: Each trip will be confirmed with the physician's office before payments will be made. Please call Logisticare 2 days in advance to schedule a reservation and receive your trip number. You will not be reimbursed for requests received more than 45 days after the travel. Reimbursement is not based on round trip, you must record both ways separately.

Do not write in this space.

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

I hereby certify that the information contained herein is true, correct and accurate and that there was no other reasonable option of transportation available

Signature _____

(Member's Signature)

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