



NEVADA MILEAGE REIMBURSEMENT TRIP LOG

Must be sent to: LogistiCare Claims Department
2552 West Erie Drive Suite 101
Tempe, AZ 85282-3100
Fax - 1-877-316-2599

DRIVER NAME: \_\_\_\_\_
DRIVER MAILING ADDRESS: \_\_\_\_\_
CITY/STATE/ZIP: \_\_\_\_\_
MEMBER NAME (If different from Driver) \_\_\_\_\_

RELATIONSHIP TO PARTICIPANT: \_\_\_\_\_
DRIVER PHONE #: \_\_\_\_\_
MEMBER MEDICAID ID#: \_\_\_\_\_

Table with 5 columns: Trip Date, Trip/Job #, Medical Provider Name & Phone #, Physician/Clinician Signature\*, Total Miles. Each row contains fields for Name and Phone # for the medical provider.

\*Each date of service must have a physician or clinician signature or a receipt from the doctor's office, pharmacy slip or discharge papers for reimbursement to be approved.

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. Signature \_\_\_\_\_