LogistiCare Claims Department
2552 West Erie Drive, Suite 101
Tempe, AZ 85282

KANSAS MILEAGE REIMBURSEMENT TRIP LOG

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

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

CITY/STATE/ZIP: _____

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/Job #	Medical Provider Name & Phone #	Physician/Clinician Signature*	Total Miles
		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. 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:_____

You may fax this form to 1-855-848-8636 or email it to LGTCReimbursement@logisticare.com.

Note: This form, when completed, will contain your personal Protected Health Information. Unless you have a method of encryption on your personal computer that enables you to encrypt your email or the scanned image of this form, email is less secure than fax. This means that by using email, there is a risk that your Personal Health Information on this form could be intercepted and compromised by third parties. You control the use of your Personal Health Information and are entitled to choose which method you wish to communicate this information to LogistiCare. By using email, you consent to the use of a less secure method of communication and waive any claims for liability against LogistiCare due to the interception of your communication by third parties.

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

Signature: _____