

MILEAGE REIMBURSEMENT TRIP LOG AND INVOICE FORM

ModivCare
Claims Department: 1-800-930-9060
Fax: 866-528-0462
Email: support.claims@modivcare.com

Mail completed form to:
ModivCare - Attn: Claims
798 Park Ave NW
Norton, VA 24273

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

DRIVER NAME:

RELATIONSHIP TO MEMBER:

DRIVER MAILING ADDRESS:

DRIVER PHONE NUMBER:

DRIVER CITY/STATE/ZIP:

PACIFICSOURCE MEMBER ID NUMBER:

MEMBER NAME (if different from driver):

MEMBER HOME ADDRESS (City/State/Zip):

Usted puede recibir este documento en otro idioma, impreso en una letra más grande o de otra manera que sea mejor para usted. También puede solicitar un intérprete. Esta ayuda es sin costo. Llame al 800-431-4135 o por TTY al 711. Aceptamos llamadas del servicio de retransmisión.

You can get this document in another language, large print, or another way that's best for you. You can also request an interpreter. This help is free. Call 800-431-4135 or TTY 711. We accept all relay calls.

The voucher must be received within 45 days or it may be denied. If you are putting more than one appointment, you must submit the completed form within 45 days from the earliest appointment shown.

| Trip date | Trip/job confirmation number | Medical provider name and phone number | One-way or Round Trip | Reason for Appointment | Physician/clinician signature* |
|-----------|------------------------------|--|-------------------------------------|------------------------|--------------------------------|
| | | Name: Phone number: | Check one: One-way Round Trip | | |
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*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.



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

Signature _____
(Member's Signature)

Do not write in this space.

Total mileage to be paid: _____ Total amount for this invoice:

Batch #: _____ Batch date: _____