LogistiCare

OREGON WVCH 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

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

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

CITY/STATE/ZIP: _____

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

Trip Date	Trip #	Healthcare 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 provider signature in order for payment to be made. NOTE: Each trip will be confirmed with the provider's office before payments will be made. Please call LogistiCare 2 days in advance to schedule a reservation and get 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.

Signature _____

(Member's Signature)

OHP-WVCH-18-074