LogistiCare

SOUTH CAROLINA MILEAGE REIMBURSEMENT TRIP LOG

Must be sent to: LogistiCare Claims Department
798 Park Avenue NW
Norton, VA 24273

DRIVER NAME: _____ **RELATIONSHIP TO MEMBER:** _____
DRIVER MAILING ADDRESS: _____ **DRIVER PHONE #:** _____
CITY/STATE/ZIP: _____
MEMBER NAME (If different from Driver): _____ **MEMBER ID#:** _____

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.
NOTE: 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:_____

I hereby certify the information contained herein is true, correct and accurate. Signature _____
(Member's Signature)