



NEW JERSEY 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)