LogistiCare

Mail To:
LogistiCare Claims Department
P.O. Box 248
Norton, VA 24273

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	*	Official use, do not write below this line			
ith the physician's office before	l. NOTE: Each trip will be confirmed w embers is .41 cents per loaded mile.	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. The mileage reimbursement rate for MaineCare members is .41 cents per loaded mile.	or clinician signature will be made. The mi	ice must have a physician c payments '	"Each date of serv
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TOTAL MILES	PHYSICIAN/CLINICIAN SIGNATURE	MEDICAL PROVIDER NAME AND PHONE	MEDICAL I	LOGISTICARE CONFIRMATION #	TRIP DATE
	(Driver)	ect and accurate.	herein is true, cor	I hereby certify the information contained herein is true, correct and accurate.	I hereby certify th
lid annual vehicle inspection n of the state of Maine.	sted below has a current and val	and valid unrestricted Maine driver's license; that the vehicle used to perform the service listed below has a current and valid annual vehicle inspection sticker issued by the state of Maine and is currently and properly registered and insured pursuant to the laws and regulation of the state of Maine.	cense; that the ve I is currently and	icted Maine driver's li the state of Maine and	and valid unrestr sticker issued by
vely certify I have a current	By Submitting this driver log do affirmatively certify I have a current	By Submit	I,		Drivers License#
	1001	- Dan ero reactionomy to mem			Driver phone#: (
	her:	Drivers relationship to member:	Zip Code:	State:	City:
		Member ID#		ddress:	Driver mailing address:
	from driver):	Member name (if different from driver):			Driver name:

Total mileage to be paid:

Total amount for this invoice:

Batch #:

Batch date: