DIALYSIS MILEAGE REIMBURSEMENT LOG & INVOICE FORM

Must be sent to: **LogistiCare, Inc.**
Missouri NEMT Billing Department
503 Oak Place, Ste. 550
Atlanta, GA 30349

DRIVER NAME:____ **DRIVER SSN:**_________________________

RELATIONSHIP TO PARTICIPANT:________________________

PARTICIPANT NAME:______________________________________ **PARTICIPANT ID:**____________________
(If different from the Driver)

DRIVER MAILING ADDRESS:____

CITY/STATE/ZIP CODE:____

DRIVER PHONE #:__(_________)_____________________________

IS TRIP A STANDING ORDER? Y N IF YES, CIRCLE THE DAYS TRAVELED WEEKLY: S M T W T F

Trip Date	Leg	MO HealthNet Provider Name	Total Miles	Clinical Signature*
	A	Name:		
	B	Name:		
	A	Name:		
	B	Name:		
	A	Name:		
	B	Name:		
	A	Name:		
	B	Name:		
	A	Name:		
	B	Name:		
	A	Name:		
	B	Name:		
	A	Name:		
	B	Name:		

*Each date of service must have a clinical signature in order for reimbursement to be approved. This form must be received within 45 days of your appointment.

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

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

Date:____________________________ **Driver's Signature:**____