MediDrive
The Drive to Better Health

# MILEAGE REIMBURSEMENT TRIP LOG AND INVOICE

## DRIVER INFORMATION

| Driver's Name | | Driver's Street Address | | |
|---|---|---|---|---|
| Driver's License # | Driver's License State | City | State | Zip Code |

## RECORD OF TRIPS

Each date of service must have a physician or clinician signature and will be reviewed with the physician's office before payments will be made.

Is trip a Standing Order? ☐ YES ☐ NO

Standing Order weekly days of travel: ☐ Su ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S

| | Trip Date | Trip Number | Total Miles | Facility Phone Number | Physician / Clinician Signature |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |

*For California members: Per All Plan Letter 17-010 from the California Department of Health Care Services, Medi-Cal beneficiaries who drive themselves to their appointment are NOT eligible for mileage reimbursement.

## SIGNATURE OF DRIVER

By submitting this trip log, I certify that at the time the services were performed I held a current and valid driver's license; and the vehicle used had passed all required state inspections and was properly registered and insured in accordance with the laws and regulations of its state of registration.

X _____ _____

Driver Signature Date

**SEND COMPLETED FORMS TO:**
**MediDrive**
**P.O. Box 2310**
**Glen Allen, VA 23508**
**FAX: 703—951--0444**
**EMAIL: claimsva@medidrive.com**
**Please allow 4-6 weeks for payment processing.**
**For any claim questions, call 1-833-633-4374**

## MEMBER INFORMATION

| Relationship to Member | Member Name | Member ID |
|---|---|---|
| | | |

| For Office Use Only | |
|---|---|
| Date received | |
| Total mileage to be paid | |
| Total invoice amount | |
| Invoice number | |

## SIGNATURE OF MEMBER

I hereby agree the above information is true and correct. I have also received, read and agreed to the gas reimbursement guidelines.

X _____ _____

Member Signature Member Name (Print)