LogistiCare

ITP Service Record (Claim Form)

Client Name:	Client Telephone:	Client Medicaid:
	( )	
ITP Name:	**ITP Telephone:**	**ITP MTI Number:**
	( )	

Trip #1

From:	To:	Miles:	Amount:
From:	**To:**	**Miles:**	**Amount:**
Authorization Number:	**Appointment Date/Time:**	**Total Miles:**	**Total Amount:**
Health Care Provider NPI:	**Health Care Provider Telephone:**	**Health Care Provider Name:**	
	( )		
I certify that this patient was seen for a Medicaid/CSHCN covered health-care service.	**Signature & Title of Health-care Provider:**	**Date Signed:**	
	➨		

Trip #2

From:	To:	Miles:	Amount:
From:	**To:**	**Miles:**	**Amount:**
Authorization Number:	**Appointment Date/Time:**	**Total Miles:**	**Total Amount:**
Health Care Provider NPI:	**Health Care Provider Telephone:**	**Health Care Provider Name:**	
	( )		
I certify that this patient was seen for a Medicaid/CSHCN covered health-care service.	**Signature & Title of Health-care Provider:**	**Date Signed:**	
	➨		

ITP Drivers: *Please note that the allowable mileage that may be claimed for reimbursement is preprinted on the form.*

AFFIDAVIT: This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim is from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws. I hereby certify that this claim contains no willful misrepresentation or falsification and that the information I have given is true and correct to the best of my knowledge and belief. **I attest that I have complied with all of the provisions of the Individual Transportation Participant Agreement when providing the transportation services for which I am seeking reimbursement.**

Signature of Individual Transportation Participant (ITP) Date

All forms must be mailed to Logisticare

ATTN: Claims

12234 N. I -35, Suite 175

Austin, TX 78753

Note: *Please retain a copy for your records*