



**SOUTH CAROLINA GAS MILEAGE REIMBURSEMENT TRIP LOG**

**Must be sent to: LogistiCare Claims Department  
503 Oak Place, Suite 550  
College Park, GA 30349**

**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** \_\_\_\_\_