Dear Member,

We have enclosed a blank reimbursement form with this letter. Feel free to make copies of the blank form for any future trips. You can also contact the LogistiCare Reservation Line to request blank copies of the form or find an online version of the form at Member Information Website (https://memberinfo.logisticare.com).

Please note that your doctor/counselor must sign the form as proof that you were at your appointment. If your form is incomplete, you will not receive payment for your trip. The distance will be calculated as the number of miles from your home to your medical appointment. Mileage reimbursement will only be paid for travel for Medicaid covered services.

Here's how it works:

1. You must call to schedule your trip at least **48 hours** before your medical appointment. **LogistiCare will be unable to back date a reservation for trips that have already occurred!**

2. When you call to schedule your trip you will receive a job number. This job number is required on the reimbursement form. **Write down the job number and date of your trip on the reimbursement form as soon as you get it from the LogistiCare reservation specialist!** Forgetting to add this is a common mistake and will cause your reimbursement to be denied. Be sure to add it to your form before you forget!

3. You must fill out the entire form **except** for the space for "Physician/Clinician Signature".

4. Take the form with you to your medical appointment and have your doctor or counselor sign it. Your doctor or counselor should sign in the "Physician/Clinician Signature" space on the form.

5. You can put up to six trips on one form.

6. **Please note that there can only be one driver on a form.** You must complete and send a separate form for each of the people driving you to your medical appointments.

7. Once your form is complete, mail it to:

   LogistiCare Claims Department
   SoonerRide Mileage Reimbursement
   2552 West Erie Drive Suite 101
   Tempe, AZ 85282-3100

8. The payment will be mailed within 30 days of the LogistiCare Claims Department receiving your completed reimbursement form.

If you have any questions, issues or concerns, please call LogistiCare at 1-877-564-5665. If a live claims representative is unable to answer your call, please leave a detailed voice message. Messages will be returned within one business day. Be sure you leave the best phone number to reach you in your voice message.

MILEAGE REIMBURSEMENT FORM

Send to: SoonerRide Mileage Reimbursement
2552 West Erie Drive Suite 101
Tempe, AZ 85282-3100

DRIVER NAME: _____ RELATIONSHIP TO MEMBER: _____

DRIVER MAILING ADDRESS: _____ DRIVER PHONE #: _____

CITY/STATE/ZIP: _____

MEMBER NAME (If different from Driver): _____ MEMBER ID #: _____

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

THIS FORM MUST BE SENT IN WITHIN 30 DAYS OF YOUR APPOINTMENT OR PAYMENT WILL BE DENIED

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 #:		

***Each date of service must have a physician or clinician signature. Each trip will be confirmed with the physician's office before payment.**

You may fax this form to 1-855-848-8636 or email it to LGTCReimbursement@logisticare.com.

Note: This form, when completed, will contain your personal Protected Health Information. Unless you have a method of encryption on your personal computer that enables you to encrypt your email or the scanned image of this form, email is less secure than fax. This means that by using email, there is a risk that your Personal Health Information on this form could be intercepted and compromised by third parties. You control the use of your Personal Health Information and are entitled to choose which method you wish to communicate this information to LogistiCare. By using email, you consent to the use of a less secure method of communication and waive any claims for liability against LogistiCare due to the interception of your communication by third parties.

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

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