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FORMERLY LOGISTICARE

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

Physician Attestation for Mileage Reimbursement Individual Appointments

County of Medicaid: _____

Medicaid Enrollee: _____

Mail Claims to: ModivCare Claims Department
798 Park Avenue NW
Norton, VA 24273
Or Fax to: 866-528-0462 within 90 days of your trip

Medicaid #:
Name:
Physical Address:
Mailing Address:
City/State/Zip:
Phone:
SSN:
Change in address?

Driver Information (If not Enrollee):

Name:
Relation to Enrollee:
Physical Address:
Mailing Address:
City/State/Zip:
Phone:
SSN: (Required for Payment)
Change in address?

Medical Provider: In signing, the Physician certifies that the Enrollee was treated at this office location on this date.

Invoice #:	Date:	Provider Name:	Provider Address:	Provider Phone:	Provider Signature:

Travel Expense:

Tolls:	Food:	Ferry:	Total:
Parking:	Hotel:		

Enrollee/Driver:

As a driver for the Medicaid Enrollee, I certify that I provided transportation for the above listed appointment on the date indicated. I am claiming reimbursement for such travel. I understand that in signing below, I am claiming that the above information, including addresses, are true. False statements may result in the referral to the Office of Medicaid Inspector General for investigation of Medicaid fraud.

Medicaid Enrollee Signature: _____ Date: __/__/____

Driver Signature: _____ Date: __/__/____

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NEW YORK STATE | Department of Health | Office of Health Insurance Programs

Mileage Reimbursement for Multiple Appointments

Appointments _____

County of Medicaid _____

Medicaid Enrollee:_____

Mail Claims to: ModivCare Claims Department
798 Park Avenue
NWNorton, VA 24273
Or Fax to: 866-528-0462 within 90 days of your trip

Medicaid #:
Name:
Physical Address:
Mailing Address:
City/State/Zip:
Phone:
SSN:
Change in address?

Driver Information (If not Enrollee):

Name:
Relation to Enrollee:
Physical Address:
Mailing Address:
City/State/Zip:
Phone:
SSN: (Required for Payment)
Change in Address?

Invoice#:	Date:	Provider Name:	Provider Address:	Phone:	Provider Signature:

Enrollee/Driver:

As a driver for the Medicaid Enrollee, I certify that I provided transportation for the above listed appointment on the date indicated. I am *claiming reimbursement for such travel. I understand that in signing below, I* am *claiming thatthe above information, including addresses, are true. False statements may result in the referral to the Office of Medicaid Inspector General for investigation of Medicaid fraud.*

Medicaid Enrollee Signature: _____ Date: __/__/____

Driver Signature: _____ Date: __/__/____