

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 60 days of your trip

Driver Information (If not Enrollee):

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

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: __/__/__

Mileage Reimbursement for Multiple Appointments

Appointments _____

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Change in address?

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Relation to Enrollee:
Physical Address:
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City/State/Zip:
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Enrollee/Driver:

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Medicaid Enrollee Signature: _____

Date: __/__/__

Driver Signature: _____

Date: __/__/__