Mileage Reimbursement Trip Log

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Trip #1 | Trip Number (Call Alivi for this before your trip) |  | Appt. Date |  | Appt. Time |  | Type | One-WayRoundtrip |
| Address where you were picked up HomeOther |  | Medical Provider Phone |  |
| Medical Provider Name |  | Medical Provider Address |  |
| I certify that this patient was seen for a Medicaid covered health service | Signature & Title of Healthcare Provider |  |

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| Trip #2 | Trip Number (Call Alivi for this before your trip) |  | Appt. Date |  | Appt. Time |  | Type | One-WayRoundtrip |
| Address where you were picked up HomeOther |  | Medical Provider Phone |  |
| Medical Provider Name |  | Medical Provider Address |  |
| I certify that this patient was seen for a Medicaid covered health service | Signature & Title of Healthcare Provider |  |

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| Trip #3 | Trip Number (Call Alivi for this before your trip) |  | Appt. Date |  | Appt. Time |  | Type | One-WayRoundtrip |
| Address where you were picked up HomeOther |  | Medical Provider Phone |  |
| Medical Provider Name |  | Medical Provider Address |  |
| I certify that this patient was seen for a Medicaid covered health service | Signature & Title of Healthcare Provider |  |

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| Trip #4 | Trip Number (Call Alivi for this before your trip) |  | Appt. Date |  | Appt. Time |  | Type | One-WayRoundtrip |
| Address where you were picked up HomeOther |  | Medical Provider Phone |  |
| Medical Provider Name |  | Medical Provider Address |  |
| I certify that this patient was seen for a Medicaid covered health service | Signature & Title of Healthcare Provider |  |

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| I have completed this form and I verify that the information on this trip log is true | Signature of Participant, Parent/Guardian, or Representative |
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**This form must be faxed from the providers office on the day of the medical appointment to Alivi at 855-710-6452.**