modivcare
FORMERLY LOGISTICARE

South Carolina
www.modivcare.com

Dear South Carolina beneficiary,

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 ModivCare reservation line to request blank copies of the form.

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, shortest distance.

Here's how it works: .32¢ / mile

1. When you call to schedule your trip you will receive a trip number. This trip number is required on the reimbursement form. **Write down the trip number and date of your trip on the reimbursement form as soon as you get it from the ModivCare 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!

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

3. 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.

4. You can put up to seven trips on one form.

5. **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.

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

   ModivCare Claims Department
   798 Park Avenue NW, 4th Floor
   Norton, VA 24273

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

8. If you have any questions please call the ModivCare Claims Department at 1-866-907-5186.

*Mileage pays for round trip. from Aides house to MD Appointment and back to Aides house

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SOUTH CAROLINA MILEAGE REIMBURSEMENT TRIP LOG

Must be sent to: ModivCare Claims Department
798 Park Avenue NW, 4th Floor
Norton, VA 24273

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. Each trip will be confirmed with the physician's office before payments will be made.

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

(Member's Signature)

EXAMPLE ONLY

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SOUTH CAROLINA MILEAGE REIMBURSEMENT TRIP LOG

Must be sent to: ModivCare Claims Department
798 Park Avenue NW, 4th Floor
Norton, VA 24273

DRIVER NAME: Your NAME **RELATIONSHIP TO MEMBER:** aide

DRIVER MAILING ADDRESS: Your Address **DRIVER PHONE #:** Your phone number

CITY/STATE/ZIP: Your address

MEMBER NAME (If different from Driver): client's name **MEMBER ID #:** clients medicaid #

Trip Date	Trip/Job #	Medical Provider Name & Phone #	Physician/Clinician Signature*	Total Miles
3/2/21	ABCDE	Name: DR. JOE Brown Phone #: 803-888-8888	DR. Brown	15
3/4/21	FGHIJ	Name: DR. Mary Sue Phone #: 803-888-8888	DR. Mary Sue	20
3/6/21	KLMNO	Name: DR. Judy Fruitty Phone #: 803-888-8888	DR. Judy Fruitty	10
		Name: Phone #:		
		Name: Phone #:		
		Name: Phone #:		
		Name: Phone #:		

DR's office signs on these lines

*Each date of service must have a physician or clinician signature in order for reimbursement to be approved. Each trip will be confirmed with the physician's office before payments will be made.

I hereby certify the information contained herein is true, correct and accurate. Signature Client Signs Here
(Member's Signature)

Mileage Reimbursement Schedule	
Invoice Due to Claims Center	Check Disbursement Date
1/14/2021	1/29/2021
1/28/2021	2/12/2021
2/11/2021	2/26/2021
2/25/2021	3/12/2021
3/11/2021	3/26/2021
3/25/2021	4/9/2021
4/8/2021	4/23/2021
4/22/2021	5/7/2021
5/6/2021	5/21/2021
5/20/2021	6/4/2021
6/3/2021	6/18/2021
6/17/2021	7/2/2021
7/1/2021	7/16/2021
7/15/2021	7/30/2021
7/29/2021	8/13/2021
8/12/2021	8/27/2021
8/26/2021	9/10/2021
9/9/2021	9/24/2021
9/23/2021	10/8/2021
10/7/2021	10/22/2021
10/21/2021	11/5/2021
11/4/2021	11/19/2021
11/18/2021	12/3/2021
12/2/2021	12/17/2021
12/16/2021	12/30/2021
12/30/2021	1/14/2022
1/13/2022	1/28/2022

Example only

If you send in claim by 3/11/2021 you should receive your check by 3/26/21