MediDrive

Mileage Reimbursement Trip Log and Invoice

DRIVER INFORMATION

Driver's Name	Driver's Street Address			
Jane Doe	0000 Main St.			
Driver's License #	**Driver's License State**	**City**	**State**	**Zip Code**
184726395	CO	Anywhere	CO	00000

RECORD OF TRI

Check "Round Trip" if the same driver will take you to your destination and bring you back.

Check "One-way" if the driver will only take you to your destination, but not bring you back.

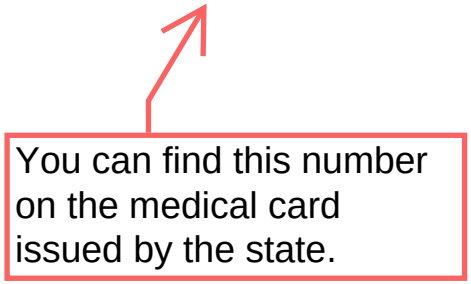
The treating facility must ent(s) a g to regulatory agencies.
Requests must include tr ay be enial of reimbursement.
Mileage is subject to validation and adjustment. Supporting documentation must be retained and provided upon request.

	TRIP DATE	TRIP NUMBER	TRIP TYPE		FACILITY PHONE NUMBER	PHYSICIAN/CLINICIAN NAME + SIGNATURE** (Please print name and sign)
1	05/11/2026	05-06-2026-154-A	☑ Round Trip	☐ One-way	+1 (111) 111-1111	Sarah Davis, MD
2			☐ Round Trip	☐ One-way		
3			☐ Round Trip	☐ One-way		
4			☐ Round Trip	☐ One-way		
5			☐ Round Trip	☐ One-way		
6			☐ Round Trip	☐ One-way		
7			☐ Round Trip	☐ One-way		

This number is assigned by MediDrive. Call us at 720-844-9610 or use the mobile app to get it.

*For California members: Per All Plan Letter 17-010 from the California Department of Health Care Services, Medi-Cal beneficiaries who drive themselves to their appointment are NOT eligible for mileage reimbursement.
**I certify that this patient was seen for a Medicaid covered health service

SIGNATURE OF DRIVER		MEMBER INFORMATION	SIGNATURE OF MEMBER	
I certify that I provided the listed transportation as documented and meet all legal requirements to operate a vehicle. I attest the trips were completed as described, are not duplicated, and no other reimbursement has been or will be sought. I understand payment is subject to validation and false information may result in denial, recovery, or further action.		Relationship to Member Spouse Member Name John Doe	I certify that the information provided is true, accurate, and complete, and that the listed transportation services were received as described. I attest that no duplicate reimbursement has been requested or received. I understand that false or misleading information may result in denial of reimbursement and potential referral for investigation.	
Driver's Name Jane Doe	Date 05/11/2026	Member ID 1234567890	Member Signature	Date 05/11/2026



SEND COMPLETED FORMS TO:

MediDrive 1801 California St. Suite 2400 Denver CO 80202 / EMAIL: **claimsco@medidrive.com**

Please allow 4-6 weeks for payment processing. For any claim questions, call **720-844-9610**