MILEAGE REIMBURSEMENT PROGRAM TRIP LOG AND CLAIM FORM

TENNESSEE CARRIERS

Return Form To:
Tennessee Carriers, Inc.
Mileage Reimbursement Program
3180 Millington Road

ITINERARY ID:

INSURANCE ID #:

MEMBER PHONE #:

MCO PLAN NAME:

DRIVER SIGNATURE: ______________________________

MEMBER NAME:

DRIVER LICENSE NUMBER #: ______________________________

MEMBER STREET ADDRESS:

DRIVER NAME: ______________________________

CITY, STATE, ZIP:

Trip Date	Origin Address Information	Destination Address Information	Physician / Clinician Signature	Authorized Mileage
	Name: Address: City, State, Zip: Phone #:	Name: Address: City, State, Zip: Phone #:		
	Name: Address: City, State, Zip: Phone #:	Name: Address: City, State, Zip: Phone #:		
	Name: Address: City, State, Zip: Phone #:	Name: Address: City, State, Zip: Phone #:		
	Name: Address: City, State, Zip: Phone #:	Name: Address: City, State, Zip: Phone #:		
	Name: Address: City, State, Zip: Phone #:	Name: Address: City, State, Zip: Phone #:		
	Name: Address: City, State, Zip: Phone #:	Name: Address: City, State, Zip: Phone #:		

Each date of service must have a Physician or other treating Provider signature for reimbursement to be approved. NOTE: All medical appointments will be confirmed before reimbursement is made. This form must be received within 180 days of the date of travel.
Mileage Reimbursement Rate is $ 0.40 per mile.*

I certify the information contained herein is true, correct and accurate. I further certify that all transportation was in accordance with the Tennessee Carriers, Inc. MILEAGE REIMBURSEMENT POLICY and was in conjunction with transportation to TennCare covered services only.

Member / Legal Guardian Signature: ______________________________ Date: ____________________