www.Modivcare.com

Dear Member,

Your friends or family members that do not live in your home can get paid for gas when they give you a ride to or from your doctor's appointment. This transportation benefit is called Gas Reimbursement. It is handled by Modivcare.

You can call Modivcare to schedule your trip at 1-866-726-1472 (Hearing loss: 1-866-288-3133), Monday through Friday, from 7 a.m. to 7 p.m. You can also call them to ask for blank copies of the Gas Reimbursement Form.

Please note: Your driver must first enroll in the Gas Reimbursement program. Your driver must submit their Social Security Number. Your driver will also need to send copies of their driver's license, vehicle insurance and vehicle registration to be enrolled. The address on their driver's license must match the address on the driver's enrollment form. To get paid, your driver must live at a separate address. Gas reimbursement will not be paid to drivers who live at the same address as the member. A member cannot be reimbursed for driving themselves to medical appointments.

Here's how it works:

1. If your driver is currently enrolled, call Modivcare at least 48 hours (two days) before your appointment to get your Trip Number. Write down the Trip Number and date of your trip on your Gas Reimbursement Form as soon as you get it! Use one form per trip.
2. Fill in the all the information on the top part of the form. List all the members the driver is bringing to the appointment. Sign your name and ask your driver to sign the form too.
3. Take the form with you to your medical appointment. Ask your provider to write in your arrival time and sign or stamp the form.
4. Your form must be filled out completely for your driver to receive payment. Forms that are missing information will be denied. Once your form is complete, mail it to:
   Modivcare Claims Department
   Louisiana Gas Reimbursement
   798 Park Ave NW, 4th Street
   Norton, VA 27273
5. When ModivCare gets your form, they will call your doctor's office to confirm you went to your appointment. Payment will be mailed to your driver within 15 days.

If you have any questions about your transportation benefits, call our Member Services team at 1-866-675-1607. (Hearing loss: 711). We're here to help Monday through Friday, 7 a.m. – 7p.m.

Gas Reimbursement Program
Driver Enrollment How-to Guide

Drivers must be enrolled in the program before they can receive payment.
No trips will be approved until the driver's enrollment is complete.

To enroll as a driver in the gas reimbursement program, follow these steps:

1. Complete and sign the attached Driver Enrollment Form.
   *For help filling out the form, call Modivcare at **1-866-726-1472**(Hearing loss: 1-866-288-3133), Monday through Friday, from 7 a.m. to 7 p.m.*

2. Make copies of the following documents:

   Your current and valid driver's license
   (Please note the driver and member must live at different addresses. Driver's physical address must match the address on the driver's license. Post office boxes will not be accepted.)
   Your current and valid auto insurance card
   Your vehicle registration

3. Send the Driver Enrollment Form and copies of your documents in ***one envelope*** to:

   Modivcare
   ATTN: Compliance
   12234 N. Interstate 35
   Plaza 35, Building B, Suite 175
   Austin, TX 78753

4. After Modivcare gets your driver's completed form and document copies, they will review the documents and call your driver once their enrollment is complete. Your driver will receive payment each time you mail a completed Gas Reimbursement Form to Modivcare. You can call Modivcare to get copies of the Gas Reimbursement Form.

Driver Enrollment Form

The purpose of the form is to include you in the gas reimbursement program.

Fill out the whole form using blue or black ink.
Please print all information clearly.
Please mail the original form with your signature to Modivcare.
Keep a copy for your records.

Relation to member	**Telephone Number:(if we need to contact you)**
☐Friend ☐Family Member ☐Other (please describe):	( )

Must match Driver's License **Last Name :**	**First Name:**	**Middle Initial:**

Social Security Number:	**Date of Birth:**

Driver's License Number: *(Please attach a copy of driver's license).*	**License Issue Date:** ***MM/DD/YYYY***	**License Expiration Date:** ***MM/DD/YYYY***

Physical Address: *This is where you live. It is also where your payment will be sent. (You must give a street address. PO boxes will not be accepted.)* *Number and Street*			

Vehicle & Insurance Information

Vehicle Identification Number (VIN): *VIN of vehicle used to drive members.*	**License Plate Number:**

Auto Insurance Policy: *Please attach a copy of your insurance card. The vehicle used to transport the member must be listed on insurance policy.*	**Policy Issue Date:** ***MM/DD/YYYY***	**Policy Expiration Date:** ***MM/DD/YYYY***

Medicaid Member Information		
Names of Medicaid members you will be driving: *You may include no more than* ***five*** *members. If you wish to change your list, you must re-submit your enrollment.*	**Medicaid ID #:**	**Medicaid member's Date of Birth:** ***MM/DD/YYYY***
1.		
2.		
3.		
4.		
5.		

Terms and Conditions of Participation

1. Before you drive a Medicaid member to their appointment, the member must first get approval for the ride and a Trip Number from Modivcare. The member can schedule their trip by calling Modivcare at 1-866-726-1472, (Hearing loss: 1-866-288-3133), Monday through Friday, from 7 a.m. to 7 p.m.
2. At the appointment, the doctor will stamp or sign the Gas Reimbursement Form.
3. You will get one gas reimbursement payment for each round trip even if you are driving more than one member.
4. Modivcare will use a computer program to determine the shortest distance in miles that your trip should take. The amount of your gas reimbursement payment is based on this mileage calculation. You will be paid per mile. The rate of payment per mile is based on the current mileage rate for state employees. This rate is set by the Louisiana Legislature.
5. All payments to drivers will be reported by Modivcare to the Internal Revenue Service (IRS).

6. You must maintain a current and valid driver's license, auto insurance, vehicle inspection and vehicle registration to remain enrolled in the program.
7. The completed Gas Reimbursement Form must be submitted within 365 days from the date you gave the member the ride. Forms received after this deadline will not be paid. *For example, if the ride was given on January 1, the form must be* ***received*** *by Modivcare no later than December 31.*

Attestation:

By signing below, I promise that the information provided in this application is true and correct. I have read the above terms and conditions. I understand that I must obey these terms and conditions to participate in the program.

I understand I must keep my own copies of all documentation to support any gas reimbursement claim. I understand that the Louisiana Department of Health (LDH) and Modivcare have the right to review any gas reimbursement claim to make sure it can be paid. They also have the right to request more information from me about any trips sent in for reimbursement.

Signature of Gas Reimbursement Driver	Date

Required Attachments:

- ð A copy of your current and valid driver's license
- ð A copy of your current and valid auto insurance card
- ð A copy of your vehicle registration

Mail this form and the required attachments to:

Modivcare
ATTN: Compliance
12234 N. Interstate 35
Plaza 35, Building B, Suite 175
Austin, TX 78753

Electronic Funds Transfer (EFT)

To enroll in EFT, complete the section below and attach a voided check or a signed letter from your bank on bank letterhead.

Type of Authorization:		
☐New ☐Change		
Last Name:	**First Name:**	**Middle Initial:**
Address: *Street, City, State, and Zip Code.*		
Telephone Number:		
( )		

Bank Information:

Bank Name:	**Bank Telephone:**
Bank Address:	
ABA/Transit Number (Routing):	**Bank Account Number:**
Account Type *Check one*	
☐Checking ☐Savings	

I hereby authorize Modivcare to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I understand that I am responsible for the validity of the information on this form. If the company erroneously deposits funds into my account, I authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited.

I understand that payment of claims will be from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I will continue to maintain the confidentiality of records and other information relating to client in accordance with applicable state and federal laws, rules, and regulations.

Signature:	**Date:**

Return this Form To:

Modivcare
ATTN: Compliance
12234 N. Interstate 35
Plaza 35, Building B, Suite 175
Austin, TX 78753

www.Modivcare.com

Gas Reimbursement Payment Request Form

Use one form per trip. Form must be filled out completely to receive payment.

FOR MEMBER AND DRIVER TO COMPLETE

Driver's First Name: ________________________ **Driver's Last Name:** ___________________________

Driver's Address: ____

Driver's Phone Number: _ ______________**Driver's Email:** _____________________________________

Name of Member(s) Being Transported on this Trip	Address of Member(s)	Driver's Relationship to Member(s)

Transportation Date:__________________________________ **Trip #:**_____________________________

Facility or Medical Provider's Name: ____

Facility/Medical Provider's Address: ____

Facility/Medical Provider's Phone Number: ____

Appointment Type:______________________ _ **Total Miles of Trip*:**_____________________________

*** ATTESTATION ***

The information provided above is correct and true to the best of my knowledge. I understand that drivers must be enrolled in the gas reimbursement program to receive payment. I also understand that each driver may only include up to five members on their enrollment form. Drivers will only receive reimbursement for transporting members listed on their enrollment form. Drivers will receive one payment for each trip.

______________________ ______________________

SIGNATURE OF DRIVER **SIGNATURE OF MEMBER**

*Actual mileage paid is based on the most direct route to the appointment and considers road closures and tolls.

FOR FACILITY/MEDICAL PROVIDER TO COMPLETE

Arrival Time: ___________________________ **Signature/Stamp:** _______________________________

<u>Mail completed form to:</u>
Modivcare Claims Department
Louisiana Gas Reimbursement
798 Park Ave NW 4th Floor Norton, VA 24273
Email: Virginia.billingoperations@modivcare.com

Fax: 866-528-0462

For vendor use. Do not write in this space.

Total mileage to be paid:_______ Total amount for this invoice:______ Batch #:______ Batch Date: ______