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:** _____

Mail completed form to:
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: _____