

## Gas Reimbursement Payment Request Form

This form can be used to request reimbursement for driving a Louisiana Healthcare Connections member to a medical appointment. Use one form per trip. Veyo must receive the completed form by mail, email or fax within 365 days of the trip. The form must be filled out completely to receive payment.

MEMBER INFORMATION			
First Name:		Last Name:	
Home Address:		City:	State: Zip Code:
DRIVER INFORMATION			
First Name:		Last Name:	
Phone Number:	Email Address:		Relationship to Member:
Home Address:		City:	State: Zip Code:
TRIP INFORMATION			
Appointment Date: (MM/DD/YYYY)	Appointment Time:		Trip Type: <input type="checkbox"/> Round Trip <input type="checkbox"/> One Way
Start Address:			<input type="checkbox"/> Home <input type="checkbox"/> Other
Medical Provider/Facility Name:		Phone Number:	
Medical Provider/Facility Address:			

FOR MEDICAL PROVIDER / FACILITY TO COMPLETE	
Licensed Medical Provider Signature/Stamp:	Print Medical Provider Name:

Attestation	
<p>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.</p>	
_____	_____
Driver Signature	Member Signature

Please submit completed forms by email, mail, or fax:	
<b>Email:</b> <a href="mailto:mrb@veyo.com">mrb@veyo.com</a>	
<b>Fax:</b> 1-855-667-2557	
<b>Mail:</b> Veyo, Attn: Gas Reimbursement, 10010 N 25th Ave. Ste 400, Phoenix, AZ 85021	