

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.

Medical Provider/Facility Address: FOR MEDICAL PROVIDER / FACILITY TO COMPLETE Licensed Medical Provider Signature/Stamp: Print Medical Provider Name: 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.	MEMBER INFORMATION						
DRIVER INFORMATION First Name: Phone Number: Email Address: City: State: Zip Code: TRIP INFORMATION Appointment Date: (MM/DD/YYYY) Start Address: Trip Type: Round Trip One Way Start Address: Phone Number: Medical Provider/Facility Name: FOR MEDICAL PROVIDER / FACILITY TO COMPLETE Licensed Medical Provider Signature/Stamp: Print Medical Provider Name: 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.	First Name:		Last Name:				
First Name: Phone Number: Email Address: City: State: Zip Code: TRIP INFORMATION Appointment Date: (MM/DD/YYYY) Appointment Time: Trip Type: Round Trip One Way Start Address: Home Other 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 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.	Home Address:		City:	State:		Zip Code:	
Phone Number: Email Address: City: State: Zip Code:	DRIVER INFORMATION	<u>.</u>					
Home Address: City: State: Zip Code: TRIP INFORMATION Appointment Date: (MM/DD/YYYY) Start Address: Trip Type: Gound Trip Gone Way Start Address: Ghome Gother Medical Provider/Facility Name: Phone Number: Medical Provider/Facility Address: Print Medical Provider Name: FOR MEDICAL PROVIDER / FACILITY TO COMPLETE Licensed Medical Provider Signature/Stamp: Print Medical Provider Name: 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.	First Name:		Last Name:				
TRIP INFORMATION Appointment Date:	Phone Number:	Email Addres	S:	Relationship to Member:			
Appointment Date: (MM/DD/YYYY) Start Address:	Home Address:		City:	Sta	te:	Zip Code:	
Start Address:	TRIP INFORMATION						
Medical Provider/Facility Name: Phone Number:		Appointment					
Medical Provider/Facility Address: FOR MEDICAL PROVIDER / FACILITY TO COMPLETE Licensed Medical Provider Signature/Stamp: Print Medical Provider Name: 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.	Start Address:						
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Driver Signature Member Signature	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						
 	Driver Signature	-	Member Signature				

Please submit completed forms by email, mail, or fax:

Email: mrb@veyo.com Fax: 1-855-667-2557

Mail: Veyo, Attn: Gas Reimbursement, 10010 N 25th Ave. Ste 400, Phoenix, AZ 85021

Last Updated: March 24, 2021