

## 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
Member's Medicaid ID		

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 Identification Number	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	

# Gas Reimbursement Payment Request Form



## FOR MEDICAL PROVIDER/FACILITY TO COMPLETE

Licensed Medical Provider Signature

Print Medical Provider Name

Licensed Medical Provider Stamp

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, even if more than one member or passenger is in the vehicle.

\_\_\_\_\_  
Driver Signature

\_\_\_\_\_  
Member Signature

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

**Email:** [mrb@veyo.com](mailto:mrb@veyo.com)

**Fax:** 1-855-667-2557

**Mail:** Veyo

Attn: Gas Reimbursement

10010 N 25th Ave. Ste 400

Phoenix, AZ 85021