# 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:** _____

| 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 takes into account road closures and tolls.

**FOR FACILITY/MEDICAL PROVIDER TO COMPLETE**

**Arrival Time:** _____ **Signature/Stamp:** _____

**Mail completed form to:**
**LogistiCare Claims Department**
**Louisiana Gas Reimbursement**
**2552 West Erie Drive, Suite 101**
**Tempe, AZ 85282-3100**

*For vendor use. Do not write in this space.*

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