Gas Reimbursement Enrollment

Please fill out the entire form below. Incomplete forms will be rejected which will delay the enrollment date. Please print.

Driver Information: Mr.☐ Mrs.☐ Ms.☐ **Date of Birth of Driver_____**

Full Name of Driver _____

Last **First** **Middle Initial** **Maiden (if applicable)**

Mailing Address of Driver _____

Street or P.O Box **City** **State** **Zip Code**

Physical Address of Driver _____

Street **City** **State** **Zip Code**

_____ _____ _____

Driver Email **Telephone Number of Driver** **Social Security Number of Driver**

I will transport the following people (limited to total of 5 individuals)

Medicaid Recipient Name	Date of Birth (mm/dd/yyyy)	Medicaid ID Number
1.		
2.		
3.		
4.		
5.		

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Check off the boxes and fill in the information below:

A. I have a Driver's license that is current and valid. Yes ☐ No ☐

B. Driver's License Number: _____

C. I have a current and valid Louisiana State Inspection sticker. Yes ☐ No ☐

D. Car License Plate Number: _____

E. I carry Liability Insurance on my car with at least the minimum amount of coverage. Yes ☐ No ☐

F. Name of Insurance Company: _____

I promise/attest that all the above information is true and accurate. I understand that false statements regarding this information can result in fines, penalties, and/or imprisonment.

_____	_____	_____
Print Name of Driver	Signature of Driver	Date of Signature

This completed form and copies of the Driver's **current**:

- Driver's License
- Registration
- Insurance Card
- Inspection Sticker (photo of current sticker)

Can be e-mailed to **Gas@meditrans.com**

Or Mailed to:

Medi Trans, LLC
Attention: Gas Reimbursement
102 Asma Boulevard Ste. 200
Lafayette, LA 70508