Gas Reimbursement Form

Email gas@meditrans.com with any questions.
All fields are required for Driver to be reimbursed.

Mail completed form to:
MediTrans Billing – ATTN: Gas Reimbursement
102 Asma Boulevard Ste. 200
Lafayette, La 70508

Driver Name: _____

Driver Mailing Address: _____

Driver City/State/Zip: _____

Driver Phone: _____

Driver Residential Address: _____

Driver relationship to Member: _____

Member Name: _____

Member DOB: _____

Medicaid ID #: _____

Member Home Address: _____

Member Phone #: _____

Please note that all required documentation for the Driver must be sent to Gas@meditrans.com before payment can be made.

Trip Date	Trip #	Medical Provider Name/Address/Phone	Member Signature	Medical Provider Signature	Medical Provider Name (Printed)

I hereby certify the information above is true, correct, and accurate.

Driver's Signature: _____

Member Signature: _____