SOUTHEASTRANS
DRIVING THE FUTURE OF TRANSPORTATION MANAGEMENT

GAS REIMBURSEMENT FORM

Name of Member Transported: ______________________ **Medicaid/Subscriber ID:** ____________________________

Driver Name: __________________________________ **Relationship to Member :** ___________________________

Driver Signature: ____ **Social Security Number:** __________________________

Driver Mailing Address: _______________________ **Phone #:**__________________________________

City, State, Zip Code: _______________________________________ **Mbr/Guradian Print & Sign for one-way only:**_______________________

Leg	Trip Date	Trip Leg ID #	Name of Medical Provider and Phone #	Medical Provider Signature & Printed Name	Miles Authorized	Claims Use Only
A						
Leg	Trip Date	Trip Leg ID #	Member Name/Guardian Signature	Member/Guardian Printed Name	Miles Authorized	Claims Use Only
B						
Leg	Trip Date	Trip Leg ID #	Name of Medical Provider and Phone #	Medical Provider Signature & Printed Name	Miles Authorized	Claims Use Only
A						
Leg	Trip Date	Trip Leg ID #	Member Name/Guardian Signature	Member/Guardian Printed Name	Miles Authorized	Claims Use Only
B						
Leg	Trip Date	Trip Leg ID #	Name of Medical Provider and Phone #	Medical Provider Signature & Printed Name	Miles Authorized	Claims Use Only
A						
Leg	Trip Date	Trip Leg ID #	Member Name/Guardian Signature	Member/Guardian Printed Name	Miles Authorized	Claims Use Only
B						
Leg	Trip Date	Trip Leg ID #	Name of Medical Provider and Phone #	Medical Provider Signature & Printed Name	Miles Authorized	Claims Use Only
A						
Leg	Trip Date	Trip Leg ID #	Member Name/Guardian Signature	Member/Guardian Printed Name	Miles Authorized	Claims Use Only
B						
Leg	Trip Date	Trip Leg ID #	Name of Medical Provider and Phone #	Medical Provider Signature & Printed Name	Miles Authorized	Claims Use Only
A						
Leg	Trip Date	Trip Leg ID #	Member Name/Guardian Signature	Member/Guardian Printed Name	Miles Authorized	Claims Use Only
B						

*Member/Guardian is required to sign and print your name on the return home Leg for each trip under the Medical Provider's signature.
**Driver signature required . See signature line at top of page. Member signature required at top of the page if one-way trip only.

Paid		Claims Use Only
Name:		Claims Use Only
Initials		Claims Use Only

Return completed forms to: **Southeastrans, Inc. 4751 Best Rd., Suite 300 Atlanta GA 30337**

or send via fax to: **678-669-7483** **(photos of paperwork will be rejected and denied)**

*** All signatures must be on the form to pay the claim***

****Keep a copy of the signed form for your records until you receive payment****