SOUTHEASTRANS
DRIVING THE FUTURE OF TRANSPORTATION MANAGEMENT

OptimaHealth
Family Care

GAS REPAYMENT PROCEDURES FOR DRIVERS

Member Requirements:
An Optima Family Care member must be eligible for Medicaid non-emergency transportation (NEMT) on the date of service and have a confirmed trip set up through Southeastrans.

Driver Requirements:

1. The driver must submit completed repayment forms for each trip requested.
2. If the driver's Social Security Number (SSN) isn't already on the form, the driver must put their SSN on the form. This is **required** for payment.
3. The driver must submit a valid mailing address and phone number for payment to be sent.
4. If preferred, the driver can be reimbursed by direct deposit. A direct deposit form must be filled out and sent in with the repayment form (see attached). Payment will be faster if this method is used.

Scheduling:

1. Trips must be scheduled **before** the appointment (standing order requests are already set up, unless the normal appointment dates change).
2. To schedule a ride, Southeastrans Call Center Representatives are available Monday through Friday 6 a.m. to 6 p.m.:
   - Medallion 4.0 (Medicaid) 1-877-892-3986
   - Optima Medicare HMO 1-866-381-4860
   - Optima Health Community Care (MLTSS) 1-855-325-7558
3. Member Services representatives are available Monday through Friday by calling:
   - Optima Medallion 4.0 Customer Care Line: 1-800-881-2166 (TTY 711) from 8 a.m. to 5 p.m.

   NOTE: If the driver is driving multiple members out of the same household for an appointment on the same date and to the same facility, the driver will **only** be reimbursed for one member in that household.

Gas Repayment Request Forms:

1. Must be signed at the time of each service. Duplicate signatures are not allowed.
2. The member (or guardian) and the driver must sign the Gas Repayment Request Form.
3. The doctor section must be filled out by the health care provider by printing and signing their name and contact phone number.
4. The form should be returned for repayment within 30 days of the medical service date to:

Southeastrans, Inc.
4751 Best Road, Ste. 300
Atlanta, GA 30337
Fax from the provider's office: 678-669-7483
(Faxes only accepted from health care provider's office)
Incomplete forms will be returned to sender.
Emailed photos of claims will be denied.

Repayment Information:

1. **Payment will be denied** for all Gas Repayment Request Forms received more than 30 days past the date of the medical service.
2. Gas Repayment Request Rate is $0.40/mile based on the miles from member's home to appointment and from appointment to member's home, as stated in our routing system. Repayment isn't provided for the ride to/from the driver's home.
3. Gas repayments are released on Fridays one week after the submission is received, as long as all documentation is received on time. *If the payment release date falls on a holiday, payment will be released on the next business day*.
4. Gas repayments to medical appointments or pharmacies are only covered within a reasonable distance from the recipient's home based on the availability of like services in the area.
5. All out-of-area and out-of-state gas repayments require prior authorization.

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****