Gas Reimbursement Form

This form can be used to request reimbursement for driving a Priority Health member to a healthcare appointment. This form can be used for up to one (1) week of gas reimbursement from the member's home address to a single medical facility location. Please complete the form and return it to Veyo within 30 days of the last medical appointment listed.

MEMBER INFORMATION		
First Name:	Last Name:	
Medicaid ID:	Date of Birth (MM/DD/YYYY):	
Phone Number:	Home Address:	
City:	State:	Zip Code:

DRIVER INFORMATION		
First Name:	Last Name:	
Phone Number:	Mailing Address:	
City:	State:	Zip Code:
Driver's License Number:	Issuing State:	Expiration Date:

TRIP INFORMATION			
Appointment Date (MM/DD/YYYY):	Appointment Time: ________ ☐ AM ☐ PM	Provider/Facility Name: Phone Number:	Provider Signature:
Appointment Date (MM/DD/YYYY):	Appointment Time: ________ ☐ AM ☐ PM	Provider/Facility Name: Phone Number:	Provider Signature:
Appointment Date (MM/DD/YYYY):	Appointment Time: ________ ☐ AM ☐ PM	Provider/Facility Name: Phone Number:	Provider Signature:
Appointment Date (MM/DD/YYYY):	Appointment Time: ________ ☐ AM ☐ PM	Provider/Facility Name: Phone Number:	Provider Signature:
Appointment Date (MM/DD/YYYY):	Appointment Time: ________ ☐ AM ☐ PM	Provider/Facility Name: Phone Number:	Provider Signature:

I certify that I went to the listed destination(s) above. I also authorize Veyo to verify the trip information given above.

X ______________________________ ______________

Driver Signature Date

Please submit completed forms by fax at 1-855-667-2557

Double check all your information as forms with partial or incorrect information will not be recorded.