LOGISTICARE SOLUTIONS

GAS REIMBURSEMENT SPENDDOWN FORM

Member First and Last Name: _____

Member Home Address: _____

Member City: _____ Member State: _____ Member ZIP: _____

Member Telephone Number: _____ Trip Number: _____

Appointment Date: _____ Appointment Time: _____ Round Trip? YES NO

Pick Up Address: _____

_____

Destination-Name of Doctor/Clinic/Facility: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Doctor/Clinic/Facility Telephone Number: _____

Total Miles: _____

Gas Reimbursement Driver Name: _____

Driver Address: _____

Driver Telephone Number: _____ Relationship to Member: _____

Medical Provider's Signature: _____ Date: _____

Driver's Signature: _____ Date: _____

Return completed form to:
LogistiCare Solutions
4149 Highline Boulevard, Suite 200
Oklahoma City, OK 73108
Fax: 1-866-355-7340
LOGISTICARE SOLUTIONS WILL RETURN ALL INCOMPLETE FORMS

FOR OFFICE USE ONLY			
Medicaid Number:		Date of Birth:	
MCO:		ICN Number:	
Treatment Type:			