Gas Reimbursement Enrollment

Please fill out the entire form below. Incomplete forms will be rejected which will delay the enrollment date. Please print.

Driver Information: Mr.____ Mrs. ____ Ms. ____ Date of Birth of Driver_____

Full Name of Driver _____

Last First Middle Initial Maiden (if applicable)

Mailing Address of Driver _____

Street or P.O Box City State Zip Code

Physical Address of Driver _____

Street City State Zip Code

_____ _____ _____

Driver Email Telephone Number of Driver Social Security Number of Driver

I will transport the following people (limited to total of 5 individuals)

Medicaid Recipient Name	Date of Birth (mm/dd/yyyy)	Medicaid ID Number															
1.	/ /																
2.	/ /																
3.	/ /																
4.	/ /																
5.	/ /																

Check off the boxes and fill in the information below:

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Check off the boxes and fill in the information below:

A. I have a current Louisiana Driver's license that is not suspended or revoked. Yes ☐ No ☐

B. Driver's License Number: _____

C. I have a current Louisiana State Inspection sticker on my car. Yes ☐ No ☐

D. Car License Plate Number: _____

E. I carry Liability Insurance on my car with at least the minimum amount of coverage. Yes ☐ No ☐

F. Name of Insurance Company: _____

I promise/attest that all the above information is true and accurate. I understand that false statements regarding this information can result in fines, penalties, and/or imprisonment.

_____	_____	_____
Print Name of Driver	Signature of Driver	Date of Signature

This completed form and copies of the Driver's **current**:

- Driver's License
- Registration
- Insurance Card
- Inspection Sticker (photo of current sticker)

Can be e-mailed to **Gas@meditrans.com**

Or Mailed to:

Medi Trans, LLC
Attention: Gas Reimbursement
102 Asma Boulevard Ste. 200
Lafayette, LA 70508