SafeRide Health

How to file for gas mileage reimbursement:

1.) Fill out the attached Claim Form (instructions below)

2.) Then return completed form(s) via one of the following methods:

Email:
communityfirst_claims@saferidehealth.com

Fax: 1 (888) 453-5398

Mail: 18302 Talavera Ridge Suite 300
San Antonio, Tx 78257

SafeRide Health

Claim Form Instructions:

****Everything highlighted in yellow or red must be filled in for a claim to be processed****

Member and ITP refers to the driver filing for gas mileage reimbursement. The MTI # is a number we assign each driver in our system.

| Client Name: | Client Telephone: | Client Medicaid ID: |
|---|---|---|
| | ( ) | |
| **ITP Name:** | **ITP Telephone:** | **ITP MTI Number:** |
| | ( ) | |

The middle portion is where you enter the specifics for this "Ride". The "Ride ID" is a number that you get from the representative when you call to schedule. You must have it on here in order for it to be processed. The lines highlighted in red are for the healthcare provider to fill in. They must be completed. Miles and amount is something we fill in.

| Trip #1 | | | |
|---|---|---|---|
| **From:** | **To:** | **Miles:** | **Amount:** |
| | | | |
| **From:** | **To:** | **Miles:** | **Amount:** |
| | | | |
| **Authorization Number/Ride ID:** | **Appointment Date/Time:** | **Total Miles:** | **Total Amount:** |
| | | | |
| **Health Care Provider NPI:** | **Health Care Provider Telephone:** | **Health Care Provider Name:** | |
| | ( ) | | |
| **I certify that this patient was seen for a Medicaid/CSHCN covered health-care service.** | **Signature & Title of Health-care Provider:** | **Date Signed:** | |
| | | | |

****If you have more than one trip to claim for you can put 2 on this form ****

At the bottom of the page it asks for a signature. It must be signed & dated in order to be complete.


****When all required fields are filled in then mail, fax, or e-mail it back to us****

# SafeRide Health ITP Service Record (Claim Form)

**Member's Health Plan: (Please indicate your health plan)** _____

| Client Name: | Client Telephone: | Client Medicaid ID: |
|---|---|---|
| | ( ) | |
| **ITP Name:** | **ITP Telephone:** | **ITP MTI Number:** |
| | ( ) | |

**Trip #1**

| From: | To: | Miles: | Amount: |
|---|---|---|---|
| | | | |
| **From:** | **To:** | **Miles:** | **Amount:** |
| | | | |
| **Authorization Number/Ride ID:** | **Appointment Date/Time:** | **Total Miles:** | **Total Amount:** |
| | | | |
| **Health Care Provider NPI:** | **Health Care Provider Telephone:** | **Health Care Provider Name:** | |
| | ( ) | | |
| **I certify that this patient was seen for a Medicaid/CSHCN covered health-care service.** | **Signature & Title of Health-care Provider:** | **Date Signed:** | |
| | | | |

**Trip #2**

| From: | To: | Miles: | Amount: |
|---|---|---|---|
| | | | |
| **From:** | **To:** | **Miles:** | **Amount:** |
| | | | |
| **Authorization Number/Ride ID:** | **Appointment Date/Time:** | **Total Miles:** | **Total Amount:** |
| | | | |
| **Health Care Provider NPI:** | **Health Care Provider Telephone:** | **Health Care Provider Name:** | |
| | ( ) | | |
| **I certify that this patient was seen for a Medicaid/CSHCN covered health-care service.** | **Signature & Title of Health-care Provider:** | **Date Signed:** | |
| | | | |

**ITP Drivers:** *Please note that the allowable mileage that may be claimed for reimbursement is preprinted on the form.*

**AFFIDAVIT:** This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim is from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws. I hereby certify that this claim contains no willful misrepresentation or falsification and that the information I have given is true and correct to the best of my knowledge and belief. **I attest that I have complied with all of the provisions of the Individual Transportation Participant Agreement when providing the transportation services for which I am seeking reimbursement.**

Signature of Individual Transportation Participant (ITP) Date

**All Claim Form should be sent to**

18302 Talavera Ridge Suite 300 San Antonio, TX 78257
communityfirst_claims@saferidehealth.com
*Fax Number: 1-888-453-5398*