Dear Recipient:

Thank you for your interest in using the Gas Mileage Reimbursement (GMR) Program . A GMR driver can be reimbursed for driving you to your health care appointments. The enclosed enrollment packet includes the documents the GMR driver must submit to SafeRide Health. Refer to the GMR driver Enrollment Checklist for a list of required items. These items must be processed and approved by the state of operation. The GMR driver cannot take any trips until the items are approved.

A GMR driver could be either of the following:

- GMR driver (Self): A Medicaid/Medicare client who transports him/herself to a health care appointment using a personal vehicle OR an individual who transports a family member who is a Medicaid/Medicare client using a personal vehicle
- GMR driver (Other): An individual who transports non-family member Medicaid/Medicare clients to a health care appointment using a personal vehicle; these individuals must undergo a Criminal History check.

The GMR driver must show on the GMR Information Page if they are applying as “Self“ or “Other.“

The required information must only be provided for the person who will be driving.

Completed documents and other required items should be submitted via mail, email or fax to:

Mailing address: 18302 Talavera Ridge, Suite 300
San Antonio, TX 78257
Email address: dellchildrens_driver@saferidehealth.com
Fax: 888-432-0026

Please remember to call SafeRide at 844-867-2742 before your GMR drives you to any appointment in order to book your appointments in our system. You can request claim forms through any of the above contacts. The form can also be found at https://www.saferidehealth.com/dell-childrens. Your GMR driver should use this form to request reimbursement. Make copies of this form for future trips.

If you have any questions about this process, please call 844-867-2742.

Sincerely,

SafeRide Health

SafeRide Health

Gas Mileage Reimbursement participant (GMR) Enrollment Checklist: Use this checklist to make sure ALLthe items needed to sign up to be a GMR driver are completed and submitted. No trips will be authorized until all documents have been approved. For help filling out these forms, call SafeRide Health Alternate Transportation department at 844-867-2742.

- ☐ A copy of your completed GMR driver information Page (pg 2)
  (*Please fill out everything, and mark N/A if a question does not apply.)*
- ☐ A copy of your completed Member/GMR Information Page (pg 3)
- ☐ The signed Terms & Conditions page (pg 4)
- ☐ A copy of your current and valid Driver's License
- ☐ A copy of your current and valid auto insurance card
  (The driver must be listed as a covered driver on the insurance.)
- ☐ A copy of your Social Security card
- ☐ A copy of vehicle registration and inspection

Important: The name listed on your driver's license and Social Security card must be the same.

For Electronic payment options be sure to include a valid email.

Please make a selection below for preferred payment option (required)

- ☐ Electronic Payment (valid email address required)
- ☐ Paper Check

All forms must be sent to SafeRide Health via one of the following:

Mailing address:
18302 Talavera Ridge, Suite 300
San Antonio, TX 78257
Email address: dellchildrens_driver@saferidehealth.com
Fax: 888-432-0026
Note: *Please retain a copy for your records.*

SafeRide Health

GMR Information Page

The purpose of the form is to obtain data to sign up to be a GMR driver. You must fill out this entire form and sign it. Please use blue or black ink. Original signature only; copies or stamped signature will not be accepted.

ITP Status: Self/Other:	**Telephone Number:(if we need to contact you)**
☐Self ☐Other	( )

Must match Driver's License **Last Name :**	**First Name:**	**Middle Initial:**

Social Security Number:(*Please attach copy of card)*	**Date of Birth:**

Driver's License Number: *(Please attach a copy of driver's license).*	**License Issue Date:** ***MM/DD/YYYY***	**License Expiration Date:** ***MM/DD/YYYY***

Physical Address: *This is where you live. (You must give a street address. PO boxes will not be accepted.)* *Number, Street, City, State, and Zip Code*

Mailing address: If same as above leave blank *Number, Street, City, State, and Zip Code.*	**Email Address:**

***Important**: the name on your driver's license, social security card must be the same*

Vehicle & Insurance Information

Vehicle Identification Number (VIN): *Please provide VIN of vehicle used to transport.*	**License Tag:**

Auto Insurance Policy Company: *Please attach a copy of insurer insurance card.* *The vehicle used to transport the member must be listed on insurance policy.*	**Policy Issue Date:** ***MM/DD/YYYY***	**Policy Expiration Date:** ***MM/DD/YYYY***

SafeRide Health

Member/GMR Information Page

If you are driving yourself or family members only, fill out **Section 1, leave Section 2 blank.**

If you are driving a person other than yourself or a family member, fill out **Section 1 and Section 2.**

Section 1

Members Health Plan: *(Please indicate your health plan)* _____

Member Name: *(the person you will be driving)*	**Medicaid ID #:**	**Member DOB:** *MM/DD/YYYY*	**Relationship to member:**
			☐Family Member/Foster ☐Non-Family Member ☐Self

Section 2 (*Facts about the GMR*)

Are you currently charged with or have you even been convicted of a crime (excluding Class C misdemeanor traffic citations)?

"Convicted" means that:

- **(a) A judgment of conviction has been entered against an individual by a Federal, State or local court, regardless of whether:**
  - **(1) There is a post-trial motion or an appeal pending; or**
  - **(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed.**
- **(b) A Federal, State or local court has made a finding of guilt against an individual.**
- **(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual, or**
- **(d) An individual has entered participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.**

☐Yes ☐No

*If **Yes**, fully explain the details including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (attach additional sheets if necessary)*

SafeRide Health

Terms and Condition of Participation

1. **Before an GMR drives a member, the application must be processed and approved. Once the application process is complete, the member must get approval for the ride from SafeRide Health. The member must call 844-867-2742 to get this approval prior to the trip otherwise the GMR will not get paid.**

2. The GMR driver must maintain a current and valid driver's license, vehicle insurance, vehicle inspection and vehicle registration during each ride.

3. The mileage reimbursement (payment) amount is based on a mileage calculation computed by SafeRide Health using a nationally recognized system of the shortest distance of the trip and not on the number of members who are given a ride. The GMR driver will be paid based on the determined mileage at the vehicle mile rate set by the State's Legislature for state employees that is in effect at the time of the ride.

4. The member must have the doctor sign the GMR Service Record (Claim Form) and the GMR driver must sign the GMR Service Record (Claim Form). The claim form must be complete with all required information.

5. Claim must be submitted within the timely filing deadline.

Attestation:

I attest that I have read the terms and conditions of participation as a Gas Mileage Reimbursement program driver and that the information provided in this application is true and correct. I understand that I must comply with the terms and conditions of participation and maintain documentation to support any mileage reimbursement claim and that Dell Children's health plan or SafeRide Health reserves the right to request and validate documentation being relied upon to support mileage reimbursement claims.

Signature of Gas Mileage Reimbursement driver (GMR) Date