SafeRide Health

UnitedHealthcare

Gas Reimbursement Form

Please submit completed forms via email, fax, or mail:

email: united_claims@saferidehealth.com

fax: 1-888-453-5398

mail: 18302 Talavera Ridge, Ste 300 San Antonio, Texas 78257

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

Please be sure to get your ride ids when booking your appointments.
Only the person designated as the driver when your reservation is made will be paid.
Reimbursement will be paid at the current approved per mile rate.
Please allow 14 days from the date you send completed form before calling about payment status.

DRIVER INFORMATION		
First Name:	Last Name:	
Relationship to Member:	Phone Number:	
Mailing Address:		
City:	State:	Zip Code:

MEMBER INFORMATION	
First Name:	Last Name:
Member Medicaid ID Number:	

* Your health care professional must sign each ride to show you were at your appointment in order for your driver to get paid. .

TRIP INFORMATION			
Appointment Date:	Ride ID:	Provider/Facility Name: Phone Number:	Provider Signature:
Appointment Date:	Ride ID:	Provider/Facility Name: Phone Number:	Provider Signature:
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Appointment Date:	Ride ID:	Provider/Facility Name: Phone Number:	Provider Signature:
Appointment Date:	Ride ID:	Provider/Facility Name: Phone Number:	Provider Signature:

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

X

Driver Signature

Date