hopelink

Gas Card Trip Request Form

Gas card reimbursement requests must be submitted within 30 days of the completed appointment. Requests submitted after 30 days may be denied. You may mail, fax, or submit documentation online via the portal at www.hopelink.org/programs/medicaid-transportation/ Hopelink Mailing Address: 14812 Main St., Bellevue, WA 98007

Phone (King County): (800) 923–7433 | Phone (Snohomish County): (855) 766–7433 | Fax: (425) 644–9447

	CLIENT INFORMATION
Client Name:	
Client Provider One Number:	
Parent or Legal Guardian Name:	
Address:	
City, State, & Zip Code:	
Phone Number:	

	DRIVER INFORMATION
Driver's Name:	
*Driver's License Expiration Date:	
*Vehicle Registration Expiration Date:	
*Insurance Expiration Date:	

^{*}These documents must be on file with Hopelink before we can process your request

Verification Information

This form can be signed by a medical professional. A medical professional (certified under Title 18) authorized to sign this document may be an MD/DO/PA-C/ARNP or other professional authorized to diagnose, prescribe and treat health/medical condition who sees the client in the client's local community.

Some trips may be randomly selected for verification during the audit process. Completing the provider section below is optional when submitting trips; however, if your trip is chosen for audit, having this section completed will significantly speed up your reimbursement.

TRIP 1 Client	: Name:			Provid	ler One #:	
Starting Address:						
Facility Name:			Facility Address:			
Facility Phone Number:			Medical Reason: (Please provide a brief description)			
Appt. Date: (mm/dd)		Appt. Time:		Round Trip: Please check one	Yes:	No:
	provider use on ton (RCW 9A.72.030) th	-		al but recommended): I certi rue and correct.	fy under penalty of pe	erjury under the laws of
The client was see	en in person at the cli	nic (not a virtual o	r telehealth appointm	ent): Please check one Yes:	No:	
Provider Name:			Provider Title:		NPI #: _	
Date:	Prov	ider Signature:				
TRIP 2 Client	: Name:			Provid	ler One #:	
TRIP 2 Client Starting Address:	: Name:			Provid	ler One #:	
	Name:		Facility Address:	Provid	ler One #:	
Starting Address:	: Name:			Provid	ler One #:	
Starting Address: Facility Name: Facility Phone		Appt. Time:	Facility Address: Medical Reason: (Please provide a	Provid Round Trip: Please check one		No:
Starting Address: Facility Name: Facility Phone Number: Appt. Date: (mm/dd) This box is for		Appt. Time: ly *Medical Provid	Facility Address: Medical Reason: (Please provide a brief description) er Verification (option)	Round Trip: Please check one	Yes:	No:
Starting Address: Facility Name: Facility Phone Number: Appt. Date: (mm/dd) This box is for the State of Washing	provider use on on (RCW 9A.72.030) th	Appt. Time: Y *Medical Provide the information co	Facility Address: Medical Reason: (Please provide a brief description) Per Verification (optional portained on this form is the second secon	Round Trip: Please check one	Yes :	No:
Starting Address: Facility Name: Facility Phone Number: Appt. Date: (mm/dd) This box is for the State of Washing The client was see	provider use on on (RCW 9A.72.030) th	Appt. Time: Y *Medical Provide the information continuous of the continuous of th	Facility Address: Medical Reason: (Please provide a brief description) Per Verification (optional portained on this form is the relebealth appointments.	Round Trip: Please check one al but recommended): / certi	Yes: ify under penalty of pe	No:

TRIP 3 Client	: Name:		Provid	ler One #:	
Starting Address:					
Facility Name:		Facility Address:			
Facility Phone Number:		Medical Reason: (Please provide a brief description)			
Appt. Date: (mm/dd)	Appt. T	ime:	Round Trip: Please check one	Yes:	No:
		edical Provider Verification (option Information contained on this form is		ify under penalty of pe	rjury under the laws of
The client was see	en in person at the clinic (not	a virtual or telehealth appointm	ent): Please check one Yes:	No:	
Provider Name:		Provider Title:		NPI #:	
Date:	Provider Sig	jnature:			
TRIP 4 Client	Name:		Provid	ler One #:	
Starting Address:					
Facility Name:					
racinty wante.		Facility Address:			
Facility Phone Number:		Facility Address: Medical Reason: (Please provide a brief description)			
Facility Phone	Appt. T	Medical Reason: (Please provide a brief description)	Round Trip: Please check one	Yes:	No:
Facility Phone Number: Appt. Date: (mm/dd) This box is for	provider use only *Me	Medical Reason: (Please provide a brief description)	al but recommended): / certi	_	
Facility Phone Number: Appt. Date: (mm/dd) This box is for the State of Washing	provider use only *Me nton (RCW 9A.72.030) that the in	Medical Reason: (Please provide a brief description) Time: edical Provider Verification (option	al but recommended): I certi true and correct.	ify under penalty of pe	
Facility Phone Number: Appt. Date: (mm/dd) This box is for the State of Washing The client was see	provider use only *Me nton (RCW 9A.72.030) that the in	Medical Reason: (Please provide a brief description) Time: Edical Provider Verification (option aformation contained on this form is a virtual or telehealth appointment.	al but recommended): I certi true and correct.	ify under penalty of pe	

TRIP 5 Client	Name:		Provid	ler One #:	
Starting Address:					
Facility Name:		Facility Address:			
Facility Phone Number:		Medical Reason: (Please provide a brief description)			
Appt. Date: (mm/dd)	Appt. T	ime:	Round Trip: Please check one	Yes:	No:
		dical Provider Verification (optional formation contained on this form is t		fy under penalty of p	perjury under the laws of
The client was see	en in person at the clinic (not	a virtual or telehealth appointme	ent): Please check one Yes:	No:	
Provider Name:		Provider Title:		NPI #:	
Date:	Provider Sig	nature:			
TRIP 6 Client				ler One #:	
Starting Address:					
Facility Name:		Facility Address:			
Facility Phone Number:		Medical Reason: (Please provide a brief description)			
Appt. Date: (mm/dd)	Appt. T	ime:	Round Trip: Please check one	Yes:	No:
		dical Provider Verification (optional formation contained on this form is t		fy under penalty of p	perjury under the laws of
The client was see	en in person at the clinic (not	a virtual or telehealth appointm	ent): Please check one Yes:	No:	
Provider Name:		Provider Title:		NPI #:	
Date:	Provider Sig				

TRIP 7 Client	: Name:			Provid	ler One #:	
Starting Address:						
Facility Name:			Facility Address:			
Facility Phone Number:			Medical Reason: (Please provide a brief description)			
Appt. Date: (mm/dd)		Appt. Time:		Round Trip: Please check one	Yes:	No:
	-	-	ler Verification (option ontained on this form is t	al but recommended): I certi true and correct.	ify under penalty of pe	rjury under the laws of
The client was see	en in person at the cli	nic (not a virtual o	r telehealth appointm	ent): Please check one Yes:	No:	
Provider Name:			Provider Title:		NPI #:	
Date:	Prov	vider Signature:				
TRIP 8 Client	: Name:			Provid	ler One #:	
Starting Address:						
Facility Name:			Facility Address:			
Facility Name: Facility Phone Number:			Facility Address: Medical Reason: (Please provide a brief description)			
Facility Phone		Appt. Time:	Medical Reason: (Please provide a	Round Trip: Please check one	Yes:	No:
Facility Phone Number: Appt. Date: (mm/dd) This box is for		y *Medical Provid	Medical Reason: (Please provide a brief description)	al but recommended): / certi		
Facility Phone Number: Appt. Date: (mm/dd) This box is for the State of Washing	ton (RCW 9A.72.030) ti	ly *Medical Provid hat the information co	Medical Reason: (Please provide a brief description) ler Verification (option ontained on this form is the second contained co	al but recommended): / certi	ify under penalty of pe	
Facility Phone Number: Appt. Date: (mm/dd) This box is for the State of Washing The client was see	ton (RCW 9A.72.030) ti	ly *Medical Provid hat the information co nic (not a virtual or	Medical Reason: (Please provide a brief description) ler Verification (option ontained on this form is to relebealth appointmental or the contained of the contained on the con	al but recommended): I certi true and correct.	ify under penalty of pen	

TRIP 9 Client	: Name:		Provid	ler One #:	
Starting Address:					
Facility Name:		Facility Address:			
Facility Phone Number:		Medical Reason: (Please provide a brief description)			
Appt. Date: (mm/dd)	Appt. Time:		Round Trip: Please check one	Yes:	No:
	provider use only *Medical laten (RCW 9A.72.030) that the information			ify under penalty of p	erjury under the laws of
The client was see	en in person at the clinic (not a virt	ual or telehealth appointm	ent): Please check one Yes:	No:	
Provider Name:		Provider Title:		NPI #:	
Date:	Provider Signatur	e:			
TRIP 10 Clie	nt Name:		Prov	rider One #:	
TRIP 10 Clie Starting Address:	nt Name:		Prov	rider One #:	
	nt Name:	Facility Address:	Prov	rider One #:	
Starting Address:	nt Name:		Prov	rider One #:	
Starting Address: Facility Name: Facility Phone	nt Name: Appt. Time:	Facility Address: Medical Reason: (Please provide a	Prov Round Trip: Please check one		No:
Starting Address: Facility Name: Facility Phone Number: Appt. Date: (mm/dd) This box is for		Facility Address: Medical Reason: (Please provide a brief description) Provider Verification (option	Round Trip: Please check one al but recommended): / certi	Yes:	No:
Starting Address: Facility Name: Facility Phone Number: Appt. Date: (mm/dd) This box is for the State of Washing	Appt. Time: provider use only *Medical I	Facility Address: Medical Reason: (Please provide a brief description) Provider Verification (option tion contained on this form is	Round Trip: Please check one al but recommended): / certitue and correct.	Yes:	No:
Starting Address: Facility Name: Facility Phone Number: Appt. Date: (mm/dd) This box is for the State of Washing The client was see	Appt. Time: * provider use only *Medical Internation (RCW 9A.72.030) that the information	Facility Address: Medical Reason: (Please provide a brief description) Provider Verification (option tion contained on this form is a rual or telehealth appointments.	Round Trip: Please check one al but recommended): / certitue and correct.	Yes: ify under penalty of p No:	No: