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: _____ **Provider 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:** ☐

This box is for provider use only ***Medical Provider Verification (optional but recommended):** *I certify under penalty of perjury under the laws of the State of Washington (RCW 9A.72.030) that the information contained on this form is true and correct.*

The client was seen in person at the clinic (not a virtual or telehealth appointment): Please check one **Yes:** ☐ **No:** ☐

Provider Name: _____ **Provider Title:** _____ **NPI #:** _____

Date: _____ **Provider Signature:** _____

TRIP 2

Client Name: _____ **Provider 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:** ☐

This box is for provider use only ***Medical Provider Verification (optional but recommended):** *I certify under penalty of perjury under the laws of the State of Washington (RCW 9A.72.030) that the information contained on this form is true and correct.*

The client was seen in person at the clinic (not a virtual or telehealth appointment): Please check one **Yes:** ☐ **No:** ☐

Provider Name: _____ **Provider Title:** _____ **NPI #:** _____

Date: _____ **Provider Signature:** _____

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TRIP 3

Client Name: _____ **Provider 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:** ☐

This box is for provider use only ***Medical Provider Verification (optional but recommended):** *I certify under penalty of perjury under the laws of the State of Washington (RCW 9A.72.030) that the information contained on this form is true and correct.*

The client was seen in person at the clinic (not a virtual or telehealth appointment): Please check one **Yes:** ☐ **No:** ☐

Provider Name: _____ **Provider Title:** _____ **NPI #:** _____

Date: _____ **Provider Signature:** _____

TRIP 4

Client Name: _____ **Provider 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:** ☐

This box is for provider use only ***Medical Provider Verification (optional but recommended):** *I certify under penalty of perjury under the laws of the State of Washington (RCW 9A.72.030) that the information contained on this form is true and correct.*

The client was seen in person at the clinic (not a virtual or telehealth appointment): Please check one **Yes:** ☐ **No:** ☐

Provider Name: _____ **Provider Title:** _____ **NPI #:** _____

Date: _____ **Provider Signature:** _____

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TRIP 5

Client Name: _____ **Provider 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:** ☐

This box is for provider use only ***Medical Provider Verification (optional but recommended):** *I certify under penalty of perjury under the laws of the State of Washington (RCW 9A.72.030) that the information contained on this form is true and correct.*

The client was seen in person at the clinic (not a virtual or telehealth appointment): Please check one **Yes:** ☐ **No:** ☐

Provider Name: _____ **Provider Title:** _____ **NPI #:** _____

Date: _____ **Provider Signature:** _____

TRIP 6

Client Name: _____ **Provider 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:** ☐

This box is for provider use only ***Medical Provider Verification (optional but recommended):** *I certify under penalty of perjury under the laws of the State of Washington (RCW 9A.72.030) that the information contained on this form is true and correct.*

The client was seen in person at the clinic (not a virtual or telehealth appointment): Please check one **Yes:** ☐ **No:** ☐

Provider Name: _____ **Provider Title:** _____ **NPI #:** _____

Date: _____ **Provider Signature:** _____

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TRIP 7

Client Name: _____ **Provider 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:** ☐

This box is for provider use only ***Medical Provider Verification (optional but recommended):** *I certify under penalty of perjury under the laws of the State of Washington (RCW 9A.72.030) that the information contained on this form is true and correct.*

The client was seen in person at the clinic (not a virtual or telehealth appointment): Please check one **Yes:** ☐ **No:** ☐

Provider Name: _____ **Provider Title:** _____ **NPI #:** _____

Date: _____ **Provider Signature:** _____

TRIP 8

Client Name: _____ **Provider 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:** ☐

This box is for provider use only ***Medical Provider Verification (optional but recommended):** *I certify under penalty of perjury under the laws of the State of Washington (RCW 9A.72.030) that the information contained on this form is true and correct.*

The client was seen in person at the clinic (not a virtual or telehealth appointment): Please check one **Yes:** ☐ **No:** ☐

Provider Name: _____ **Provider Title:** _____ **NPI #:** _____

Date: _____ **Provider Signature:** _____

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TRIP 9

Client Name: _____ **Provider 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:** ☐

This box is for provider use only ***Medical Provider Verification (optional but recommended):** *I certify under penalty of perjury under the laws of the State of Washington (RCW 9A.72.030) that the information contained on this form is true and correct.*

The client was seen in person at the clinic (not a virtual or telehealth appointment): Please check one **Yes:** ☐ **No:** ☐

Provider Name: _____ **Provider Title:** _____ **NPI #:** _____

Date: _____ **Provider Signature:** _____

TRIP 10

Client Name: _____ **Provider 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:** ☐

This box is for provider use only ***Medical Provider Verification (optional but recommended):** *I certify under penalty of perjury under the laws of the State of Washington (RCW 9A.72.030) that the information contained on this form is true and correct.*

The client was seen in person at the clinic (not a virtual or telehealth appointment): Please check one **Yes:** ☐ **No:** ☐

Provider Name: _____ **Provider Title:** _____ **NPI #:** _____

Date: _____ **Provider Signature:** _____

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