MILEAGE REIMBURSEMENT DRIVER AGREEMENT

Terms and Conditions

I understand that I am voluntarily providing transportation to assist a Priority Health member. I assume all responsibility for any and all risk of accident, automotive damage or bodily injury that I may sustain while providing this service.

Further, I, for myself and my heirs, executors, administrators and assigns, hereby release, waive and discharge Priority Health and SafeRide Inc., and its officers, directors, employees, and agents of and from any and all claims which I or my heirs, administrators and assigns ever may have against any of the above for, on account of, by reason of or arising in connection with providing this service, and hereby waive all such claims, demands and causes of action.

Attestation

I understand that by completing this form, I attest that:

I am a Priority Health Member, and I will drive myself. I understand that my only payment for these services will be gas reimbursement, and that I will receive payment after submitting a complete and approved claim.

OR

I understand that by completing this form, I attest that:

1. I will drive a Priority Health Member. I understand that my only payment for these services will be gas reimbursement, and that I will receive payment after submitting a complete and approved claim.

2. I am not excluded from participation in any federal health care program, and I am not listed on the MDHHS sanctioned provider list or the U.S. Inspector General of the Department of Health and Human Services exclusion list.

3. I have a valid driver's license.

4. I have not been convicted under a federal or state law after August 21, 1996, for a felony criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

5. I will disclose and report to SafeRide Inc. any felony conviction related to a controlled substance.

6. I will disclose to SafeRide Inc. my driving history, including any traffic violations.

7. I do not have ANY of the following convictions in the past two years:

    a. More than two (2) moving violations.

    b. Operating While Intoxicated (OWI)

    c. Driving Under the Influence (DUI)

Exceptions to the traffic violation exclusion:

• A family member or foster parent with any of the traffic convictions listed may receive reimbursement for NEMT provided to a member who is unable to consent because of an intellectual or developmental disability or a legal guardianship, with the written consent of their legally responsible party.

• A family member or foster parent with any of the traffic convictions listed may receive reimbursement for NEMT provided to a member who is able to consent to the family member or foster parent providing NEMT after the convictions are disclosed to the participant and the participant signs an acknowledgement form

☐ **I certify that I have read and agreed to the above terms and conditions and attestation.**

Signature _____ Date _____

SafeRide Health

Driver Registration Form - Michigan Medicaid

Please remember to include a photocopy of the driver's license and vehicle insurance when submitting this form.
Forms submitted without these attachments will not be approved.
*Please be sure to submit your insurance verification after each renewal or policy change.

DRIVER DETAILS (Submit a photocopy of the driver's license)

First Name	Last Name	
Driver's License Number	Expiration Date (MM/DD/YYYY)	Issuing State
Mailing Address	City / State	Zip Code
Email Address	Phone Number	

VEHICLE INSURANCE INFORMATION (Submit a photocopy of active vehicle insurance)

Vehicle Insurance Name	
Vehicle Insurance Number	**Expiration Date (MM/DD/YYYY)**

MEMBER DETAILS

First Name	Last Name
MedicaidNumber	Date of Birth (MM/D D/YYYY)
Relationship to Member	

PAYMENT INFORMATION (Please only select one payment option)

☐ ****Direct Deposit** **RECOMMENDED (Payment notification will be sent via Interchecks** Please note that iCloud emails will not be accepted

☐ **Physical** Check

DRIVER AGREEMENT FOR GAS REIMBURSEMENT: I understand that I am voluntarily providing transportation to assist a Priority Health member. I assume all responsibility for any and all risk of accident, automotive damage or bodily injury that I or the passengers may sustain while providing this service. I further understand that if the member, or any accompanying person, is under the age of 18 it is my responsibility to know and comply with State law regarding child seats, booster seats, seat belts, and/or requirements to have these minors sit in the rear seat. Further, I, for myself and my heirs, executors, administrators and assignees, hereby release, waive, and discharge Priority Health and SafeRide Health, and its officers, directors, employees, and agents of and from any and all claims which I, my heirs, administrators or assignees ever may have against any of the above for, on account of, by reason of, or arising in connection with providing this service, and hereby waive all such claims, demands, and cases of action. I understand that my only payment for these services will be gas reimbursement, and that I will receive payment after submitting a complete and approved claim.

DRIVER AGREEMENT: I certify that I have read and agree to the above the above terms and conditions:

Signature: _____ **Date:** _____

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

priority_driver@saferidehealth.com

1-888-432-0026

106 Jefferson St, Ste 300
San Antonio, Texas 78205

Double check all your information as forms with partial or incorrect information will not be recorded