ENROLLMENT PACKET FOR THE LOUISIANA MEDICAL ASSISTANCE PROGRAM (Louisiana Medicaid Program)

Friends and Family Transportation

(Enrollment packet subject to change without notice)

(PT 42)
Revised 04/14

Revised 04/14

FRIENDS AND FAMILY TRANSPORTATION PROVIDER ENROLLMENT FORM

This section is for Provider Enrollment Unit use only:

Driver Parish Code: **Begin Date: / /** **Rep:**

Provider#: **End Date: / /** **Extension:**

This Friends and Family Enrollment Form is for: ☐ **New Enrollment** ☐ **Recertification** ☐ **Add-On**

Trans # _____ **Trans # _____**

Please fill out the entire form below. Incomplete forms will be rejected which will delay the enrollment date. Please print.

Driver Information ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** **Date of Birth of Driver: ____/____/_____**

Full Name of Driver _____

Last **First** **Middle Initial** **Maiden (if applicable)**

Mailing Address of Driver _____

Street or P.O. Box **City** **State** **ZIP Code**

_____ _____ _____-_____-_____

Parish of Driver **Telephone Number of Driver** **Social Security Number of Driver**

I will transport the following people (limited to total of 5 individuals)

Medicaid Recipient Name	Date of Birth (mm/dd/yyyy)	Medicaid Plastic Card Control Number(16 digit CCN Number on Medicaid Card)
1.	/ /	
2.	/ /	
3.	/ /	
4.	/ /	
5.	/ /	

Check off the boxes and fill in the information below:

A . I have a current Louisiana Driver's license that is not suspended or revoked. ☐ Yes ☐ No Driver's License Number: _____

B. I have a current Louisiana State inspection sticker on my car. ☐ Yes ☐ No Car License Plate Number: _____

C. I carry liability insurance on my car and it is at least the minimum. ☐ Yes ☐ No Name of Insurance Company: _____

I promise/attest that all of the above information is true and accurate. I understand that false statements regarding this information can result in fines, penalties, and/or imprisonment.

_____ _____ _____

Print Name of Driver Signature of Driver Date of Signature

Signature must be witnessed by two individuals who are NOT FAMILY MEMBERS or PARTICIPANTS and who are 18 years of age or older.

_____ _____ _____

Print Name of Witness #1 Signature of Witness #1 Date of Signature

_____ _____ _____

Print Name of Witness #2 Signature of Witness #2 Date of Signature

Please mail to:
Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159