LogistiCare

Fax: 1-877-601-0535

Standing Order Form
California

Member's Name: _____ **Date of Birth:** / / **Gender:** F M

Member's insurance ID # _____ **Insurance Type:** _____

***Member's weight:** **Member's height:**

Appointment Information

Appointment Days	Appointment Time	Level of Service
☐ Monday ☐ Tuesday ☐ Wed ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	Appointment time: am/pm Return Time: am/pm Start Date: / / End date: / / ☐ Ongoing	☐ Ambulatory ☐ Wheelchair ☐ Wheelchair –Transferable ☐ Wheelchair Bariatric ☐ Stretcher **(Requires Prior Auth from Plan)** ☐ Stretcher Bariatric **(Requires Prior Auth from Plan)** ☐ Escort ☐ BLS Ambulance **(Requires Prior Auth from Plan)** Authorization # for indicated LOS:_____ Authorizing Person: _____ Authorizing Person Phone: _____ **Weight** **Height**

Pick Up location

Facility Name: _____**Room #** _____

Street Address _____ **Apt/bldg** _____

City: _____ **State** _____**Zip**_____

Phone #: **Steps at pick-up location? Y N How Many?**

Destination

Facility Name: _____**Room #** _____

Street Address _____ **Apt/bldg** _____

City: _____ **State** _____**Zip**_____

Phone #:

Holiday Closure (circle)

Treatment Type				Ordering Party
☐ Dialysis	New Years Day	Open	Closed	**Name:** _____
☐ Chemo/Radiation	MLK	Open	Closed	**Title:** _____
☐ Rehab	Memorial Day	Open	Closed	**Phone #: (** **)** _____
☐ Mental Health	Independence Day	Open	Closed	**Fax #: (** **)** _____
☐ Wound Care	Labor Day	Open	Closed	**Is the member able to sign the driver's log? Y N**
☐ Other	Veterans Day	Open	Closed	**If not, the reason why** _____
	Thanksgiving	Open	Closed	
	Christmas	Open	Closed	

To secure a standing order, this form must be completed and submitted to LogistiCare. If the treating facility does not want to participate in the completion of this form, the member's regularly schedule trips will need to be called in on a monthly basis