YOU CAN ALSO MAKE APPOINTMENTS AT:
1-800-698-8457

LogistiCare

Medicaid Bus Pass Program

Please fill in the following information: **NEW ADDRESS** ☐

Name_____ **Phone**: (____) _____

Address: _____City: _____Zip:_____

Date of Birth: _____

Medicaid # _____ Gold Card# _____

Do you have an Escort Traveling? Yes / No Do you have a Disability? Yes / No
If yes, please identify: _____

Doctor's information:

1.- Doctor's name:_____ Phone(____)_____

Address: _____City and Zip:_____

Appointment Date(s): _____ Treatment:_____

Weekly appointment please circle the days: S M T W T F S

2.- Doctor's name:_____ Phone(____)_____

Address: _____City and Zip:_____

Appointment Date(s): _____ Treatment: _____

Weekly appointment please circle the days: S M T W T F S

3.- Doctor's name:_____ Phone(____)_____

Address: _____City and Zip:_____

Appointment Date(s): _____ ____ Treatment:_____

Weekly appointment please circle the days: S M T W T F S

4.- Doctor's name:_____ Phone(____)_____

Address: _____City and Zip:_____

Appointment Date(s): _____Treatment:_____

Weekly appointment please circle the days: S M T W T F S

5.- Doctor's name:_____ Phone(____)_____

Address: _____City and Zip:_____

Appointment Date(s): _____Treatment:_____

Weekly appointment please circle the days: S M T W T F S

6.- Doctor's name:_____ Phone(____)_____

Appointment Date(s): _____Treatment:_____

Fax to: LogistiCare: 1-866-429-5285
OR mail to:
LogistiCare - 5875 NW 163RD St. Suite 203 Miami Lakes, FL 33014