Transportation Request Form

*** PLEASE COMPLETE ALL AREAS OF FORM OR TRIP WILL NOT BE SCHEDULED***

Fax : (866) 779-5242

Facility: ____

Person Requesting trip:__________________________ Title __________________

Patient/Client Name: Last: _____________________ First:___________________

ID # _______________________ Date of Birth: _____/______/______ (*MM/DD/YY*)

Phone: (_____) ______ - ________ Fax #: (______) ______ - ________ Escort: Yes_____ No _____

Type of transportation requested: (select one) : TRIP WILL NOT BE SCHEDULED IF LEVEL OF TRANSPORT NOT SELECTED

Ambulatory___ Cane/walker___ Wheelchair___ Electric or Standard Transferable or NonTransferable

Stretcher ____ Pt's Hight ________ Pt's Weight ________

***Date:* _______________ *Insurance:*________________________**

Pick-up Location - Address: ________________________________Suite/Rm. # _____,

City ______________ Zip ________Phone #: ( )______-__________ *Appointment time:* __________

Drop-off Location-Address: ________________________________Suite/Rm. # _____,

City ______________, Zip ________ Dr.'s Name ____

Nature of appointment: ____

Phone #: ( )_______-__________ Return pick up time _________ or will call _________

To be processed all fields MUST be completed and legible
Failure do so could result in trip not being processed

(MUST BE SUBMITTED 72 HOURS PRIOR TO THE APPOINTMENT DAY)

To be filled out by LogistiCare

A leg Pick-up: __________AM PM B leg Pickup: __________ AM PM Confirmation # __________