



GA Operations
 1640 Phoenix Blvd. Ste. 200
 College Park, GA 30349

STANDING ORDER FORM

(The Standing Order is Only Active for 30 Days)

SOUTHWEST FAX # 877-601-9795

SOUTHWEST PHONE # 866-570-3126

Member's Name:	Medicaid ID #:	DOB: ___/___/___	<input type="checkbox"/> New <input type="checkbox"/> Update Existing
Facility Name:	Phone #:	Fax #:	

APPOINTMENT INFORMATION

Appointment Days <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	Appt. Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Ambulatory <input type="checkbox"/> Cane <input type="checkbox"/> Walker/Rollator <input type="checkbox"/> Escort	
	Return Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Wheelchair <input type="checkbox"/> Manual <input type="checkbox"/> Electric	
	Start Date: ___/___/___	Is the member able to transfer to an ambulatory vehicle: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	End date: ___/___/___	<input type="checkbox"/> Stretcher <input type="checkbox"/> Oxygen ___ Liters <input type="checkbox"/> Isolation	
	Special Needs:	Height: _____ Weight: _____	
	<input type="checkbox"/> Oxygen <input type="checkbox"/> Car Seat	<input type="checkbox"/> Ongoing	<input type="checkbox"/> One Way <input type="checkbox"/> Round Trip
		Can the Member sign the driver's log? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Will signature status be permanent? <input type="checkbox"/> Yes <input type="checkbox"/> No	

GAS REIMBURSEMENT INFORMATION

Driver Name: _____	Mailing Address: _____
Driver Phone # _____	SSN: _____

PICK-UP INFORMATION

Facility/Complex Name:	Phone #:
Address/Apt:	City, State Zip:

DROP-OFF INFORMATION

Facility/Complex Name:	Phone #:
Address/Suite:	City, State Zip:

Procedure Code: Treatment Type: <input type="checkbox"/> Dialysis <input type="checkbox"/> Adult Day <input type="checkbox"/> Mental Health <input type="checkbox"/> Other _____	Ordering Party: Name: _____ Title: _____ Phone#: () _____ Fax#: () _____
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I, the **licensed physician or certified professional named below**, acknowledge that I understand that transportation is provided to treatments which are Medicaid covered services and hereby declare under potential penalty of Medicaid Fraud to the best of my knowledge and belief the above referenced information is accurate.

Physician or Certified Professional: **PRINTED NAME/TITLE:** _____

SIGNATURE: _____ **DATE:** _____

“Caution: This information contains confidential and proprietary trade secrets, the release of which could cause competitive harm. It is not subject to disclosure under any freedom of information act or open records act law or regulation. Do not further disclose.”