LogistiCare

TRANSPORTATION REQUEST FORM

(For one time trip)

MUST BE SUBMITTED 2 BUISNESS DAYS (48 HOURS) PRIOR TO THE APPOINTMENT DAY
PLEASE COMPLETE ALL FIELDS OF FORM OR TRIP CAN NOT BE SCHEDULED

FACILITY NAME					
PERSON REQUESTING TRIP:					
PHONE:		**POSITION;**			
MEMBER INFORMATION	Last Name		First Name		
TUFTS ID #		DATE OF BIRTH	___/___/_____ (MM/DD/YY)		
PHONE #		FAX #		ESCORT	☐ YES ☐ NO

TYPE OF TRANSPORTATION REQUESTED (select one)

*****WE ARE NOT ABLE TO SCHEDULE TRANSPORTATION IF LEVEL OF SERVICE IS NOT SELECTED**

- ☐ AMBULATORY
- ☐ WHEELCHAIR
- ☐ DOOR-DOOR NEEDED: Y N REASON: _____
- ☐ NON-MEDICAL STRETCHER
- ☐ ALS
- ☐ BLS

SPECIAL NEEDS/EQUPIMENT SUPPLIES_____

For Wheelchair/Stretcher Transports: Height _____ Weight: _____ Stairs: _____

DATE OFSERVICE		INSURANCE	

PICK-UP INFO

FACILITY/RESIDENCE NAME				SUITE/ROOM/APT #	
ADDRESS					
CITY		STATE		ZIP	
PHONE		APPOINTMENT TIME		☐ AM ☐ PM	

DROP-OFF INFORMATION

FACILITY NAME:					
ADDRESS				SUITE / ROOM/APT #	
CITY		STATE		ZIP	
PHONE		DR.'S NAME/DEPT			
PICK-UP/RETURN TIME	☐ AM ☐ PM	**TREATMENT TYPE:		WILL CALL	☐ YES ☐ NO

To be processed, **ALL** fields MUST be completed and legible. Failure do so could result in trip not being processed
Please fax complete form to: ((855) 864-0954
Facility Phone: (855)-483-6530