



LogistiCare Solutions
 2602 S 47TH ST
 Phoenix AZ 85034

NM BCBS CENTENNIAL STANDING ORDER FORM

FAX # 866-402-0522
 PHONE # 866-400-8233

Member's Name:	Insurance Type:	
Member's Insurance ID#	Gender: Female / Male	DOB: ___/___/___

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	Level of Service: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheelchair <input type="checkbox"/> Mass Transit <input type="checkbox"/> Stretcher <input type="checkbox"/> Gas Reimbursement If Stretcher provide precautions: _____	
	Return Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	Start Date: ___/___/___ Height: _____ Weight: _____	
	End date: ___/___/___	Ongoing <input type="checkbox"/>	
	Special Needs:	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	
Physician's Signature: _____			

PICK-UP INFORMATION

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

DROP-OFF INFORMATION

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

Treatment Type: <input type="checkbox"/> Dialysis <input type="checkbox"/> Other _____ <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Mental Health <input type="checkbox"/> Adult Day Care	Ordering Party: Name: _____ Title: _____ Phone#: () _____ Fax#: () _____
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NAME: _____ **SIGNATURE:** _____ **DATE:** _____

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