LogistiCare Solutions
2602 S 47TH ST
Phoenix AZ 85034

NM TRANSPORTATION REQUEST FORM

(For one time trip)
Must be submitted within 72 hours prior to the appointment date
Please complete all fields on the form or trip will not be scheduled
FAX # 866-402-0522
PHONE # 866-400-8233

Facility Name:	Trip Requestor:	Date of Trip:
Member's Name (Last, First, MI)		Insurance Type:
Medicaid ID #		Special needs:
DOB: _____/_____/_____	Escort: ☐ Yes ☐ No	
Phone #	Fax #	

LEVEL OF SERVICE:

☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Gas Reimbursement ☐ Mass Transit ☐ BLS ☐ ALS

If Stretcher/BLS/ALS provide precautions:_____

Wheelchair/Stretcher: Please provide the following information

Type of Wheelchair: ☐ MANUAL ☐ ELECTRIC ☐ SCOOTER ☐ N/A

Weight:_____ Height:_____Stairs:(how many steps):_____ Ramp: ☐ Yes ☐ No

Is the member able to transfer to a sedan vehicle: ☐ Yes ☐ No

PICK-UP INFO

Facility Name/Residence:	Phone #
Address:	City, State ZIP

DROP-OFF INFO

D/O Facility/Complex Name:	Phone #
Address/Suite:	City, State, ZIP
Requested Pick Up Time_____ ☐ AM ☐ PM Appointment Time _____ ☐ AM ☐ PM ☐ One Way or ☐ Round Trip	Return Time: _____ ☐ AM ☐ PM **OR** Will Call ☐ Yes ☐ No

In order 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)

NAME (Please Print): _____**SIGNATURE:** _____ **DATE:** _____