LogistiCare

Standing Order Request Form
For Appointments Occurring 3 Days or More per Week

Facility Dept.: 127 Washington Avenue, 5th Floor, North Haven, CT Phone (866) 428-2351 Fax (877) 457-3334

Member's Name: _____ DOB: ____-____-____ Gender: M__ F__ Medicaid #: _____

Member's Insurance Type: _____ *(if applicable)* Member's Insurance #:_____ *(if applicable)*

Appointment Days: ( ) Sun ( ) Mon ( ) Tue ( ) Wed ( ) Thurs ( ) Fri ( ) Sat

Start date _____Name of parent/guardian *(if applicable)*: _____

Emergency Contact: _____ Relationship to Patient: _____ Phone: ( ) _____-_____

Level of service: ( ) Mass Transit ( ) Ambulatory ( ) Ambulette

Requested by: _____Relation: _____ Phone: ( ) _____-_____

Patient Condition: _____ Facility Medicaid Provider #: _____

Treatment Type: _____ Procedure Code(s): _____/_____ Medicaid Billing Code: _____

Can Member Sign Driver's Log? Yes: ___ No: ___ *If no, is member's inability to sign permanent?* Yes: ___ No: ___ *Please explain if member's inability is permanent*: _____

Pick Up: *Check if it's the person's home* ( ) *or a facility* ( ). *If a facility, please name it:* _____

Pick up street address: _____ Bldg: _____ Apt: _____

City: _____ State: _____ Zip: _____ Phone: ( ) _____-_____ Cell: ( ) _____-_____

Directions: _____

Appointment Time: _____ AM / PM Suggested Pick Up Time from Home: _____ AM / PM

Drop Off Information:

Drop Off At (Facility Name): _____ Contact Name: _____

Street address: _____ Bldg: _____ Apt: _____

City: _____ State: _____ Zip: _____ Phone: ( ) _____-_____ Cell: ( ) _____-_____

Directions: _____ Physician Name: _____

Return Pick Up Time: _____ AM / PM Please specify if trip is: One-way trip: ( ) or Round trip: ( )

Authorization

When will patient's authorization expire? *(e.g., ongoing, 90 days, etc)*: _____

Days Treatment Needed: _____ Length of Time per Treatment: _____

I am requesting non-emergency Medicaid transportation for the member named above only for those days when the member will receive a Medicaid-payable treatment at the facility named above. I affirm that the information entered above is accurate.

Doctor's or Certified Professional's Signature: _____ Date: _____ Phone: ( ) _____-_____

For LGTC use only

Recertified: _____ Terminated: _____ Date: _____ By: _____

Reason for recertifying/terminating the standing order: _____

PLEASE RETURN THIS FORM VIA FAX TO: (877) 457-3334 - ATTENTION: FACILITY DEPARTMENT