



LogistiCare Solutions LLC
545 N. Pleasantburg Drive,
Suite 202
Greenville, SC 29607

Standing Order Form - Repeating Appointments Three Days or Greater Per Week

Date: _____ Medicaid Member's Name: _____
Medicaid Number: _____ Region/County: _____ Date Of Birth: _____
Appointment Days: Sun Mon Tue Wed Thu Fri Sat
Start Date: _____ Level of Service Ambulatory Wheelchair Weight: _____
Requires: Escort Car Seat
Requested By: _____ Relationship: _____ Phone Number: _____
Patient's Condition: _____
Treatment Type: (e.g., C & A Day Treatment) _____
Treatment Procedure Code(s) (e.g.Y3018): _____, _____, _____, _____, _____
Facility Medicaid ID Number: _____

Pick-Up and Destination Information

From: _____ Street Address: _____ Bldg: _____ Apt: _____
City: _____ Zip Code: _____ State: _____ Phone Number: () _____

Directions: _____

Appointment Time: _____ AM/PM Pick-Up Time: _____ AM/PM

Drop off at (Program Name): _____

Street Address: _____ Bldg: _____ Apt: _____

City: _____ Zip Code: _____ State: _____ Phone Number: () _____ - _____

Physician's Name _____

Directions: _____

Return Pick-Up Time: _____ AM/PM ONE WAY ROUND TRIP

Patient's authorization expiration date: _____

(e.g. initial authorization for C & A Day Treatment Y3018 is for 450 one hour treatments)

I, the licensed physician or certified professional named above, 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 Signature: _____

For LGTC use only

Recertified () or terminated _____ on _____ by _____

Reason for recertifying/terminating the standing order: _____

Region 1 866-420-6253

PLEASE RETURN VIA FAX TO
Region 2 877-272-3939

Region 3 877-272-3990