LogistiCare

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

INDIVIDUAL TRIP REQUEST FORM

Must Be Submitted at Least 3 Business Days Prior to the Appointment Day

FAX # 877-813-5599
PHONE # 866-469-2824

Member Name:	Medicaid ID #:	DOB: ____/____/____
Date of Service: _____/_____/_____	Treatment Type:	
Requesting Facility:		Special Needs/Instructions:
Phone #:	Fax #:	

LEVEL OF SERVICE:

☐ Ambulatory ☐ Cane ☐ Walker/Rollator Escort: ☐ Yes ☐ No

*(If Member resides ½ mile or less from a fixed route stop, he/she must use mass transit **unless** a mass transit restriction form is on file.)*

☐ Wheelchair: Weight:_____ Height:_____ Stairs: _____

Is the Member able to transfer to an ambulatory vehicle?: ☐ Yes ☐ No Wheelchair Type: ☐ Manual ☐ Electric

☐ Stretcher*: Weight:_____ Height:_____ Stairs: _____

☐ Oxygen: ____ Liters ☐ Isolation **(A Medical Necessity Form is required for **all** stretcher transport requests.)*

PICK-UP INFORMATION

Facility Name/Residence:		Address:
City, State ZIP:		Room/Apartment #:
Phone #:	Alt. Phone #:	**Appointment Time:** _____ ☐ AM ☐ PM

DROP-OFF INFORMATION

Facility Name:	Address:	
City/State/ZIP:	Building Name:	Suite #:
Phone #:	Physician / Department:	
Return Time: _____ ☐ AM ☐ PM	**Will Call** ☐ Yes	**One-Way** ☐ Yes

NAME: _____ **SIGNATURE:** _____ **DATE:** _____

REFERENCE # _____

"Caution: This information contains confidential and proprietary trade secrets, the release of which could cause competitive harm. It is not subject to disclosure under any freedom of information act or open records act law or regulation. Do not further disclose."