

LogistiCare Solutions 2602 S 47TH ST Phoenix AZ 85034

OH TRANSPORTATION REQUEST FORM

(For one time trip)

Must be submitted within <u>72 hours</u> prior to the appointment date Please complete all fields on the form or trip will not be scheduled

FAX # 866-910-7681 PHONE # 866-910-7680

| Facility Name: | Trip Requeste | or: Date of Trip: |
|---|---------------|----------------------|
| Member's Name (Last, First, MI) | | Insurance Type: |
| Medicaid ID # | | Special needs: |
| DOB:/ | Escort: | |
| Phone # | Fax # |] |
| LEVEL OF SERVICE: | | |
| ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Mass Transit ☐ Gas Reimbursement ☐ 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 |
| Appointment Time | | Return Time: |
| ☐ One Way or ☐ Round Trip | | 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): | SIGNATUF | RE: DATE: |

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