



LogistiCare Solutions  
 2602 S 47<sup>TH</sup> ST  
 Phoenix AZ 85034

### WI 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 # 888-589-6164

PHONE # 888-589-6163

Facility Name:		Trip Requestor:		Date of Trip:	
Member's Name (Last, First, MI)				Insurance Type:	
Medicare ID #			Special needs:		
DOB: ____/____/____		Escort: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Phone #		Fax #			
<b>LEVEL OF SERVICE:</b>					
<input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheelchair <input type="checkbox"/>					
<u>Wheelchair:</u> Please provide the following information					
Type of Wheelchair: <input type="checkbox"/> MANUAL <input type="checkbox"/> ELECTRIC <input type="checkbox"/> SCOOTER <input type="checkbox"/> N/A					
Weight:_____ Height:_____ Stairs:(how many steps):_____ Ramp: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the member able to transfer to a sedan vehicle: <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>PICK-UP INFO</b>					
Facility Name/Residence:			Phone #		
Address:			City, State ZIP		
<b>DROP-OFF INFO</b>					
D/O Facility/Complex Name:			Phone #		
Address/Suite:			City, State, ZIP		
Appointment Time _____ <input type="checkbox"/> AM <input type="checkbox"/> PM			Return Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM <b>OR</b>		
<input type="checkbox"/> One Way    or <input type="checkbox"/> Round Trip			Will Call <input type="checkbox"/> Yes <input type="checkbox"/> 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: \_\_\_\_\_**

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