



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

### IL 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 # 877-272-3629

PHONE # 877-917-4149

Facility Name:		Trip Requestor:		Date of Trip:	
Member's Name (Last, First, MI)				Insurance Type:	
Medicaid 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"/> Stretcher <input type="checkbox"/> Gas Reimbursement <input type="checkbox"/> Mass Transit <input type="checkbox"/> BLS <input type="checkbox"/> ALS If Stretcher/BLS/ALS provide precautions: _____					
<u>Wheelchair/Stretcher:</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		
Requested Pick Up Time _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Appointment Time _____ <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> One Way   or <input type="checkbox"/> Round Trip			Return Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM <b>OR</b> 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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