



LogistiCare Solutions
 2602 S 47TH ST
 Phoenix AZ 85034

IL STANDING ORDER FORM

FAX # 877-272-3629
 PHONE # 877-917-4149

Member's Name:	Insurance Type:	
Member's Insurance ID#	Gender: Female / Male	DOB: ___/___/___

APPOINTMENT INFORMATION

Appointment Days <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	Appt. Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Return Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	Level of Service: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheelchair <input type="checkbox"/> BLS <input type="checkbox"/> Mass Transit <input type="checkbox"/> Stretcher <input type="checkbox"/> ALS <input type="checkbox"/> Gas Reimbursement If Stretcher/BLS/ALS provide precautions: _____
	Start Date: ___/___/___	Height: _____ Weight: _____
	End date: ___/___/___	Ongoing <input type="checkbox"/>
	Special Needs:	Can the member sign the driver's log? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Will signature status be permanent? <input type="checkbox"/> Yes <input type="checkbox"/> No
Physician's Signature: _____		

PICK-UP INFORMATION

Facility/Complex Name:	Phone #
Address:	City, State, Zip

DROP-OFF INFORMATION

Facility/Complex Name:	Phone #
Address:	City, State, Zip

Treatment Type: <input type="checkbox"/> Dialysis <input type="checkbox"/> Other _____ <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Mental Health <input type="checkbox"/> Adult Day Care	Ordering Party: Name: _____ Title: _____ Phone#: () _____ Fax#: () _____
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NAME: _____ SIGNATURE: _____ DATE: _____

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