LogistiCare

FAX request to 866-907-1491 Forty-eight (48) hours before trip date

*If you have any questions, please call the Facility Assistance line at **866-679-6330***

This form must be completed in its entirety or the trip may be subject to denial

Today's Date: _____ County/City: _____ Appt. Date: _____

Consumer Name: _____ Date of birth: _____

Gender: ☐Male ☐Female Weight: _____lbs. ID #:_____

Insurance Type: (Check One) ☐Medicaid ☐Anthem ☐Optima ☐ Chartered Health ☐CareNet ☐VA AMERIGROUP

Can Consumer sign the driver's log? ☐**Yes** ☐**No** How long is he/she expected to be unable to sign?

Start Date Unable to Sign:_____ End Date Unable to Sign:_____ ☐Indefinitely

Reason Consumer is unable to sign: _____

Trip Type (check appropriate trip type)

☐ **Standing Order (Recurring trip for at least 90 days in duration)** ☐**Non-Reoccurring Appointment**

Specific Appointment Reason: _____ CPT Code:_____

Appointment Time: _____ ☐AM ☐PM Return Time: _____☐AM ☐PM

Appointment Day(s): ☐Mon ☐Tue ☐Wed ☐Thurs ☐Fri ☐Sat ☐Sun

(Please check Appropriate Day(s))

☐Service Authorization Number: _____

Other special considerations: _____

☐ **Hand to Hand** ☐**Door to Door** ☐**Curb to Curb** ***"Consumer must meet criteria."***

☐**Attendant Information needed, please call:**_____

Medical Necessity Determination

☐Ambulatory ☐Wheelchair ☐Van Stretcher ☐Stretcher (Non-Emergency Ambulance)

(Check level of service)

ICD9 Code: _____**(necessary if LOS is stretcher or wheelchair)**

Pick-Up Information

From: _____ Physical Address:_____

Suite: _____ City: _____Zip: _____ Ph: _____

Drop-Off Information

To: _____ Physical Address:_____

Suite: _____ City: _____Zip: _____ Ph: _____

I certify that the above consumer medical information is accurate.

Print Name: _____ Title: _____

Signature: _____ Phone: _____

Date:_____ ☐Request Public Transit? ☐Mileage Reimbursement

Does your facility provide its own transportation? ☐Yes ☐No (check one)

Requested Provider Name: *"not guaranteed"*_____