



VA Operations  
 Utilization Review Department  
 798 Park Ave NW  
 Norton, VA 24273

**STANDING ORDER FORM**

(Please fax to the number provided at least 48 hours before the initial trip)

FAX # 866.907.1491

PHONE # 866.679.6330

**For member and driver safety, all activities may be recorded.**

Member's Name:	Insurance Type:	<input type="checkbox"/> New <input type="checkbox"/> Update Existing
Member's Medicaid ID #:	Gender: Female / Male	DOB: ___/___/___

**APPOINTMENT INFORMATION**

<b>Appointment Days</b> <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	Level of Service: (Please select the appropriate Level of Service) <input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheelchair <input type="checkbox"/> Stretcher Van <input type="checkbox"/> Stretcher <input type="checkbox"/> Bariatric Wheelchair <input type="checkbox"/> Bariatric Stretcher Member's condition that requires wheelchair/stretcher:
	Return Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
	Start Date: ___/___/___	Height: _____ Weight: _____ (Height and Weight are needed for all wheelchair and stretcher requests)
	End date: ___/___/___	Assistance Level: <input type="checkbox"/> Hand-to-Hand <input type="checkbox"/> Door-to-Door <input type="checkbox"/> Curb-to-Curb
	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 <b>Requested Provider's Name (not guaranteed):</b>

**PICK-UP INFORMATION**

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

**DROP-OFF INFORMATION**

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

<b>Treatment Type:</b> <input type="checkbox"/> Adult Daycare <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Therapeutic Day TX <input type="checkbox"/> Day Support <input type="checkbox"/> Supported Employment <input type="checkbox"/> Dialysis	<b>Requesting Party:</b> Name: _____ Title: _____ Phone#: ( ) _____ Fax#: ( ) _____
--	---

**NAME:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

“Caution: This information contains confidential and proprietary trade secrets, the release of which could cause competitive harm. It is not subject to disclosure under any freedom of information act or open records act law or regulation. Do not further disclose.”