LogistiCare

VA Operations
Reservations Call Center
798 Park Ave NW
Norton, VA 24273
Phone: 866.679.6330
Fax: 866.679.6329

TRANSPORTATION REQUEST FORM

(For single date trip requests)
Must Be Submitted 5-Business Days Prior to the Appointment Day
Trip Requests with Less Than a 5-Business Day Notice Must Be Called In
To be processed ALL fields MUST be completed and legible; failure to do so will result in the trip request being denied.

Facility:	Trip Requestor:	Professional Title:
Requestor Phone #	Requestor Fax #	Trip Date:

Member Name (Last, First, MI)		Special Needs: (Please include special equipment or pick-up/drop –off instructions)
DOB: _____/_____/_____	Escort: ☐ Yes ☐ No	
Insurance Type:	Medicaid ID #	☐ Car Seat (*Member must provide car seat)*

LEVEL OF SERVICE AND LEVEL OF ASSISTANCE:

☐ Curb-To-Curb ☐ Door-To-Door ☐ Hand-To-Hand

☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Bariatric Stretcher ☐ Stretcher Van

Medical Condition that Requires Wheelchair or Stretcher:_____

Weight:_____ Height:_____ Stairs(#):_____ Wheelchair Type: ☐ Manual ☐ Electric

(Height and Weight are Required for All Wheelchair, Stretcher and Stretcher Van Requests)

Is the member able to transfer from his or her wheelchair, in and out of a vehicle safely: ☐ Yes ☐ No

PICK-UP INFORMATION

P/U Facility Name/Residence:	Phone #
Address/Apt:	City, State ZIP

DROP-OFF INFORMATION

D/O Facility/Complex Name:	Phone #
Address/Suite:	City, State Zip:
Appointment Time: _____ ☐ AM ☐ PM ☐ One Way or ☐ Round Trip	Will Call ☐ Yes ☐ No Return Time: _____ ☐ AM ☐ PM
Appointment Reason:	☐ Public Transit ☐ Mileage Reimbursement Does your facility provide its own transportation? ☐ Yes ☐ No Requested Provider Name:(“not guaranteed”)

NAME: _____**SIGNATURE:** _____ **DATE:** _____

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