LogistiCare

**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**

| | | |
|---|---|---|
| Member's Name: | Insurance Type: | ☐ New ☐ Update Existing |
| Member's Medicaid ID #: | Gender: Female / Male | DOB: ____/____/____ |

## APPOINTMENT INFORMATION

| | | |
|---|---|---|
| **Appointment Days**<br>☐ Monday<br>☐ Tuesday<br>☐ Wednesday<br>☐ Thursday<br>☐ Friday<br>☐ Saturday<br>☐ Sunday | Appt. Time:<br>_____ ☐ AM ☐ PM<br>Return Time:<br>_____ ☐ AM ☐ PM | Level of Service: (Please select the appropriate Level of Service)<br>☐ Ambulatory ☐ Wheelchair<br>☐ Stretcher Van ☐ Stretcher<br>☐ Bariatric Wheelchair ☐ Bariatric Stretcher<br>Member's condition that requires wheelchair/stretcher: |
| | Start Date:____/_____/_____ | Height: Weight:<br>**(Height and Weight are needed for all wheelchair and stretcher requests)** |
| | End date:____/_____/_____ | Assistance Level:<br>☐ Hand-to-Hand ☐ Door-to-Door ☐ Curb-to-Curb |
| | Special Needs: | Can the Member sign the driver's log? ☐ Yes ☐ No<br>Will signature status be permanent? ☐ Yes ☐ No<br>**Requested Provider's Name *(not guaranteed)*:** |

## PICK-UP INFORMATION

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

## DROP-OFF INFORMATION

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

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|---|---|
| **Treatment Type:**<br>☐ Adult Daycare ☐ Substance Abuse<br>☐ Behavioral Health ☐ Therapeutic Day TX<br>☐ Day Support ☐ Supported Employment<br>☐ Dialysis | **Requesting Party:**<br>Name:_____<br>Title:_____<br>Phone#: ( )_____<br>Fax#: ( )_____ |

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