



**Medicaid Trip Order Form**

**Must be received by 12:00pm -2 business days prior to appointment date**

**If a first time request, please include a complete Medical Necessity Form**

**We will only take requests for Medical Appointments for the current month**

**Can member sign yes \_\_ no \_\_ If No, how long will member not be able to sign \_\_\_\_\_**

*Please Indicate your Preferred Provider*

**PLEASE PRINT**

TRIP DATE: \_\_\_\_\_ APPOINTMENT TIME \_\_\_\_\_: \_\_\_\_\_ am/pm

PICK-UP TIME \_\_\_\_\_: \_\_\_\_\_ am/pm RETURN TIME \_\_\_\_\_: \_\_\_\_\_ am/pm

**Height:** \_\_\_\_\_

**Weight:** \_\_\_\_\_

Ambulatory ( ) Ambulatory MAV ( ) Wheelchair ( ) Wheelchair MAV ( ) BLS/Stretcher ( )

Will client have an escort accompany them (Family member or aide)? ( )

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**CLIENT/RECIPIENT INFORMATION**

NAME: \_\_\_\_\_

*If Client is Medicaid Eligibility Pending (Medically Needy) Check Box*

*If Client is Medicaid Pending please provide Social Security Number:* \_\_\_\_\_

MEDICAID #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

APPOINTMENT NATURE: \_\_\_\_\_

CAN THE RIDER PHYSICALLY SIGN THE DRIVER TRIP LOG? YES ( ) NO ( )

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**PICK-UP LOCATION**

PICK-UP FACILITY: Residence ( ) Facility Name: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE #: ( ) \_\_\_\_\_ ALT PHONE #: ( ) \_\_\_\_\_

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**DESTINATION INFORMATION**

DESTINATION FACILITY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE #: ( ) \_\_\_\_\_ DR'S FULL NAME: \_\_\_\_\_

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ORDERED BY: \_\_\_\_\_

TITLE: \_\_\_\_\_ FACILITY: \_\_\_\_\_

PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_

**PLEASE FAX TO: 877-457-3316**