MEDICAID TRANSPORTATION REQUEST

TO: Medicaid Transportation, 375 W. Onondaga St. #15, P.O. Box 11998, Syracuse, NY 13218

Fax completed form to 315-299-2786

FROM: _____at _____

Phone #: (_____) _____-_____ Fax #: (_____) _____-_____

DATE COMPLETED: _____/_____/_____

Client Name: _____ Sex: □ Male or □ Female

Medicaid # _____ DOB: ___/____/____ Client's Phone #: (____) ____-_____

Pickup Address: _____

Drop off Address: _____

Client's Phone #: (_____) _____-_____

Pickup/Start Date:____/____/____ Pickup Time:_____

Reason for Trip (s) _____

Transportation Vendor:_____

Appt. Time: _____

Round Trip: □ Yes or □ No, If "Yes" approx time of return pickup: _____

Standing Order: □ Yes or □ No, If "Yes" days of week □ M □ Tu □ W □ Th □ F □ Sa □ Su

Addition to Standing Order: □ Yes or □ No

Transp. Mode: □ Bus □ Taxi □ Wheelchair □ Escort □ Stretcher

If wheelchair, does client □ Have or □ Need a wheelchair

Client's medical provider: _____ NPI #:_____

Special Instructions: _____

_____

_____

_____

If you any questions regarding this form, or any Medicaid Transportation Prior Approval request, please call Medical Answering Services, LLC at 315-701-7550. **Please destroy all previous versions of this form.**

Revised 06/14/2011