



**GA Operations**  
**1640 Phoenix Blvd. Ste. 200**  
**College Park, GA 30349**

**STANDING ORDER FORM**

*(The Standing Order is Only Active for 30 Days)*

**CENTRAL FAX # 877-601-0613**

**CENTRAL PHONE # 866-570-6128**

Member's Name:	Medicaid ID #:	DOB: ___/___/___	<input type="checkbox"/> New
Facility Name:	Phone #:	Fax #	<input type="checkbox"/> Update Existing

**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	<input type="checkbox"/> Ambulatory <input type="checkbox"/> Cane <input type="checkbox"/> Walker/Rollator <input type="checkbox"/> Escort		
	Return Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Wheelchair <input type="checkbox"/> Manual <input type="checkbox"/> Electric		
	Start Date: ___/___/___	Is the member able to transfer to an ambulatory vehicle: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	End date: ___/___/___	<input type="checkbox"/> Stretcher <input type="checkbox"/> Oxygen ___ Liters <input type="checkbox"/> Isolation		
	Special Needs: <input type="checkbox"/> Oxygen <input type="checkbox"/> Car Seat	<input type="checkbox"/> Ongoing	<input type="checkbox"/> One Way <input type="checkbox"/> Round Trip	
		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			

**GAS REIMBURSEMENT INFORMATION**

Driver Name: _____	Mailing Address: _____
Driver Phone # _____	SSN: _____

**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>Procedure Code:</b> <b>Treatment Type:</b> <input type="checkbox"/> Dialysis <input type="checkbox"/> Adult Day <input type="checkbox"/> Mental Health <input type="checkbox"/> Other	<b>Ordering Party:</b> Name: _____ Title: _____ Phone#: (    )_ _____ Fax#: (    )_ _____
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**I, the licensed physician or certified professional named below, acknowledge that I understand that transportation is provided to treatments which are Medicaid covered services and hereby declare under potential penalty of Medicaid Fraud to the best of my knowledge and belief the above referenced information is accurate.**

**Physician or Certified Professional: PRINTED NAME/TITLE:**

**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.”