



## Standing Order Request Form for Appointments Occurring 3 Days or More per Week

Texas Exceptions Department - Phone: 877-564-9835 Fax 877-585-8793 (M – F 8:00 a.m. to 5:00 p.m.)

Non-emergency medical transportation is **not** available for clients who can transport themselves without mileage reimbursement.

Client's Name: \_\_\_\_\_ DOB: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Gender: M\_\_ F\_\_ Medicaid # \_\_\_\_\_  
 Name of parent/guardian (if applicable): \_\_\_\_\_ Phone ( ) \_\_\_\_ - \_\_\_\_  
 Appointment Days: ( ) Sunday ( ) Monday ( ) Tuesday ( ) Wednesday ( ) Thursday ( ) Friday ( ) Saturday  
 Start date: \_\_\_\_\_ Requested by: \_\_\_\_\_ Relation to the member: \_\_\_\_\_ Phone ( ) \_\_\_\_ - \_\_\_\_

Level of Service: ( ) **Bus**. Bus stops are within 1/4 mile of residence & 1/4 mile of the medical provider. Client can walk 1/4 mile.  
 ( ) **Gas Reimbursement** ( ) **Client uses Volunteer Driver** \_\_\_\_\_  
 ( ) **Ambulatory**. Client can walk.  
 ( ) **Wheelchair**: Client cannot walk, is confined to a wheelchair & requires a lift-equipped wheelchair van. Client's Height: \_\_\_\_\_ Client's Weight: \_\_\_\_\_  
 Manuel/Electric? \_\_\_\_\_ Weight of Wheelchair: \_\_\_\_\_ Can the client transfer? Yes / No

Patient Condition: \_\_\_\_\_ Facility NPI #: \_\_\_\_\_  
 Treatment Type: \_\_\_\_\_ Procedure Code(s): \_\_\_\_\_  
 Can the client sign the Driver's Log? Yes: \_\_\_ No: \_\_\_ *If no, is client's inability to sign permanent?* Yes: \_\_\_ No: \_\_\_ *Please explain if client's inability is permanent:* \_\_\_\_\_

**Pick Up:** Check if it's the person's home ( ) or a facility ( ). If a facility, please name it: \_\_\_\_\_

**Please confirm the client's pickup address with the client as some clients change residence frequently.**

Pick up street address: \_\_\_\_\_ Bldg: \_\_\_\_\_ Apt: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_ - \_\_\_\_ Cell: ( ) \_\_\_\_ - \_\_\_\_  
 Directions: \_\_\_\_\_  
 Appointment Time: \_\_\_\_\_ AM / PM Suggested Pick Up Time from Home: \_\_\_\_\_ AM / PM

**Drop Off At:** Facility Name: \_\_\_\_\_ Contact Name: \_\_\_\_\_  
 Street address: \_\_\_\_\_ Bldg: \_\_\_\_\_ Apt: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_ - \_\_\_\_ Cell: ( ) \_\_\_\_ - \_\_\_\_  
 Directions: \_\_\_\_\_ Physician Name: \_\_\_\_\_  
 Return Pick Up Time: \_\_\_\_\_ AM / PM Please specify if trip is: One-way trip: ( ) or Round trip: ( )

**Authorization:** I request non-emergency medical transportation for the named client only for those days when the client will receive a covered service at the named facility. I affirm that the information above is accurate, and that I am a physician, physician's assistant, nurse midwife, or nurse practitioner, social worker.

Signature: \_\_\_\_\_ Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Please print your name: \_\_\_\_\_ Phone: ( ) \_\_\_\_ - \_\_\_\_

**For Modivcare use only:** Recertified: \_\_\_\_\_ Terminated: \_\_\_ Date: \_\_\_\_\_ By: \_\_\_\_\_  
 Reason for recertifying/terminating the standing order: \_\_\_\_\_

**PLEASE FAX THE COMPLETED FORM TO THE TEXAS EXCEPTIONS DEPT. at 877-585-8793**