Single Trip Reservation Form

Facility Department
P.O. Box 464, North Haven, CT 06473
Facility Line: 866–428–2351
Facility Fax: 877–457–3334

PLEASE COMPLETE ALL AREAS OF FORM OR TRIP WILL NOT BE SCHEDULED
(MUST BE SUBMITTED *NO LATER THAN* 72 HOURS PRIOR TO THE APPOINTMENT)

*Facility Name: ____

*Person Requesting: ____

********Traveling with Aid/Comp: Yes or NO ********

*Patient/Client Name:____

*Last: ____________________ First:________________ Social Security # _

*Date of Birth: ____/_____/_____ *Medicaid ID # - -

DSS Worker Name & Phone Number (if pending T-19)

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

TRANSPORT/APPOINTMENT

*APPOINTMENT TYPE/REASON:_________________*DATE

*APPOINTMENT TIME: *ESTIMATED RETURN TIME: _______________

CONFIRMATION #: PICK-UP TIME:

ALL BELOW INFORMATION IS REQUIRED. IF ANY FIELD IS LEFT BLANK NO RIDE WILL BE SCHEDULED.

Pick-up Location - Address: Suite/Room. # ,

City/Town ____________________ ZIP CODE Phone: ( ) -

Drop-off Location-Address: ________________________________Suite/Room#

City/Town __________________________ZIP CODE ______________

Dr.'s Name:___________________________________ Phone #: ( ) -

Type of transportation requested: (select one):

TRIP WILL BE SCHEDULED AS LIVERY IF LEVEL OF TRANSPORT NOT SELECTED

Livery (Car)_____ (Curb to curb service)

Ambulette _________(Member has wheelchair). Medical reason:

Requested Provider ____