INDIVIDUAL TRIP REQUEST FORM

Must Be Submitted at Least 3 Business Days Prior to the Appointment Day

FAX # 877-813-5599 PHONE # 866-469-2824

Member Name:	Medicaid ID #:	DOB: ____/____/____
Date of Service: ____/____/____	Treatment Type:	
Requesting Facility:		Special Needs/Instructions:
Phone #:	Fax #:	

Is Member DART Certified? YES ____________ NO

LEVEL OF SERVICE

❑ Ambulatory ❑ Cane ❑ Walker/Rollator Escort: ❑ Yes ❑ No

(If Member resides ½ mile or less from a fixed route stop, he/she must use mass transit ***unless*** *a mass transit restriction form is on file.)*

❑ Wheelchair: Weight: __________ Height: ___________ Stairs: ___________

Is the Member able to transfer to an ambulatory vehicle?: ❑ Yes ❑ No Wheelchair Type: ❑ Manual ❑ Electric

❑ Stretcher*: Weight: __________Height:___________ Stairs:

❑ Oxygen: ____ Liters ❑ Isolation *(A Medical Necessity Form is required for **all** stretcher transport requests.)

PICK-UP INFORMATION

Facility Name/Residence:		Address:
City, State ZIP:		Room/Apartment #:
Phone #:	Alt. Phone #:	**Appointment Time:** ______________ ❑ AM ❑ PM

DROP-OFF INFORMATION DOES THIS FACILITY ALLOW STRETCHER DROP-OFF'S? – ❑YES or ❑ NO

Facility Name:	Address:	
City/State/ZIP:	Building Name:	Suite #:
Phone #:	Physician / Department:	
Return Time: ______________ ❑ AM ❑ PM	**Will Call** ❑ Yes	**One-Way** ❑ Yes

NAME:________________________ **SIGNATURE:**_______________________ **DATE:**

REFERENCE #

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