modivcare

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

STANDING ORDER FORM

FAX # 877.813.5599
PHONE # 866.469.2824

		0 New 0 Update Existing
Member Name:	**Medicaid #:**	**DOB:** ____/____/____
Facility Name:	**Phone #:**	**Fax #:**

APPOINTMENT INFORMATION

Days		
☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun	**Appt. Time:** 0 **AM** 0 **PM**	0Ambulatory 0 Cane 0 Walker/Rollator 0 Escort *(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)*
	Return Time: 0 **AM** 0 **PM**	**Is Member DART Certified? YES NO**
	Start Date ___/___/___ End Date ___/___/___	0 Wheelchair 0 Manual 0 Electric Is the member able to transfer to an ambulatory vehicle: 0 Yes 0 No *(Medical Necessity Form required for **all** wheelchair transport requests)*
	Weight: **Height:** **Stairs:**	0 Stretcher 0 Oxygen ____ Liters 0 Isolation *(Medical Necessity Form required for **all** stretcher transport requests)*
	Treatment Type:	**Special Needs:**

PICK-UP INFORMATION

Facility/Residence:	**Address:**
City/State/Zip:	**Room/Apartment #:**
Phone #:	**Alt #:**

DROP-OFF INFORMATION

Facility Name:	**Address:**	
City/State/Zip:	**Building Name:**	**Suite #:**
Phone #:	**Physician / Department:**	

Must be submitted 3 days prior to the first trip

NAME: **SIGNATURE:** **TITLE:**

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