**HI STANDING ORDER FORM**

**Fax: 1-866-475-5745**

**Phone: 1-866-475-5744**

|  |  |  |
| --- | --- | --- |
| Member’s Name**:** | Insurance Type**:** | |
| Member’s Insurance ID# | Gender**:** Female / Male | DOB: \_\_\_\_\_/\_\_\_\_/\_\_\_\_ |

**APPOINTMENT INFORMATION**

|  |  |  |
| --- | --- | --- |
| **Appointment Days**  🞏 Monday  🞏 Tuesday  🞏 Wednesday  🞏 Thursday  🞏 Friday  🞏 Saturday  🞏 Sunday | **Appt. Time:**  **\_\_\_\_\_\_\_\_\_\_** 🞏 AM 🞏 PM | **Level of Service:**  🞏 Ambulatory 🞏 Wheelchair 🞏 BLS  🞏 Mass Transit 🞏 Stretcher 🞏 ALS  🞏Gas Reimbursement |
| **Return Time:**  **\_\_\_\_\_\_\_\_\_\_** 🞏 AM 🞏 PM | If Stretcher/BLS/ALS provide precautions: |
| **Start Date:** \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | Height**:** Weight**: ­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_ |
| **End date:** \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | Ongoing 🞏 |
| Special Needs**:** | Can the member sign the driver’s log? **🞏** Yes **🞏** No |
| Will signature status be permanent? **🞏** Yes **🞏** No |
| **Physician’s Signature:** |

**PICK-UP INFORMATION**

|  |  |
| --- | --- |
| Facility/Complex Name: | Phone: |
| Address: | City, State, Zip: |

**DROP-OFF INFORMATION**

|  |  |
| --- | --- |
| Facility/Complex Name: | Phone: |
| Address: | City, State, Zip: |

|  |  |
| --- | --- |
| **Treatment Type:**  🞏 Dialysis 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 Substance Abuse  🞏 Mental Health  🞏 Adult Day Care | **Ordering Party:**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**By submitting this form, I agree to cooperate with ModivCare’ s fraud, waste and abuse mitigation efforts and will provide attendance verifications reports and re-certifications of standing orders as reasonably requested.**

**NAME** (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_