**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**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_