IOWA FACILITY REGISTRATION FORM

Please complete this form if you serve Medicaid clients who need standing orders (frequent repeat trips) for transportation.

Date: _____

Facility Name: _____

NPI #: _____

Iowa Medicaid Provider #: _____

Address: _____

City: _____ St: _____ Zip Code: _____

Phone #: _____ Fax #: _____

E-mail Address: _____ Web Site: _____

Standard Days and Hours of Operation: _____

Observed Holidays: _____

Administrator/Director: _____

Primary Contact Person (designated to communicate with LogistiCare regarding transportation): _____

Contact Phone #: _____

Emergency Contact Person: _____

Emergency Phone #: _____