

TRANSPORTATION REQUEST FORM

(For one time trip)

MUST BE SUBMITTED <u>2 BUISNESS DAYS (48 HOURS)</u> PRIOR TO THE APPOINTMENT DAY PLEASE COMPLETE ALL FIELDS OF FORM OR TRIP CAN NOT BE SCHEDULED

FACILITY NAME															
PERSON REC	PERSON REQUESTING TRIP:														
PHONE: POSITION;															
MEMBER INFORMATION Last Name			First Name												
TUFTS ID#						D	DATE OF BIRTH						_ (MM/DD/YY)		
PHONE #		FAX#							ESCORT			□ YE	NO		
	TYPE OF TRANSPORTATION REQUESTED (select one)														
***WE ARE NOT ABLE TO SCHEDULE TRANSPORTATION IF LEVEL OF SERVICE IS NOT SELECTED L AMBULATORY L WHEELCHAIR L DOOR-DOOR NEEDED: Y N REASON:															
L NON-MEDICAL STRETCHER L ALS L BLS SPECIAL NEEDS/EQUPIMENT SUPPLIES															
For Wheelchair/Stretcher Transports: Height Weight: Stairs:															
DATE OFSER	INSURANCE														
	PICK-UP INFO														
FACILITY/RES								SUITE/ROOM/APT#							
ADDRESS															
CITY						ST	TATE			ZIP					
PHONE						APPOINTMENT TIME				□ AM					
DROP-OFF INFORMATION															
FACILITY NAME:															
ADDRESS								SUITE / ROOM/APT #							
CITY			STATE			E				ZIP					
PHONE				DR.'S NAME/DI											
PICK-UP/RETURN TIME				IPM	**7	**TREATMENT TYPE:							VILL ALL		

To be processed, **ALL** fields MUST be completed and legible. Failure do so could result in trip not being processed Please fax complete form to: ((855) 864-0954 Facility Phone: (855)-483-6530

[&]quot;Caution: This information contains confidential and proprietary trade secrets, the release of which could cause competitive harm. It is not subject to disclosure under any freedom of information act or open records act law or regulation. Do not further disclose."