

STANDING ORDER FORM

At least three days per week, minimum 60 (sixty) days

FAX # 866-569-1910

Phone # 866-569-1908

DEPT. EMAIL: MIExceptions@modivcare.com

Member's Name:	Insurance Type:	<input type="checkbox"/> New <input type="checkbox"/> Update Existing
Member's Insurance ID#:	DOB: ____/____/____	Gender: Female / Male

APPOINTMENT INFORMATION

Appointment Days <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	Appt. Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	Start Date: ____ / ____ / ____
	Return Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	End date: ____ / ____ / ____ <input type="checkbox"/> Ongoing
	Level of Service: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Medivan <input type="checkbox"/> Wheelchair <input type="checkbox"/> Stretcher <input type="checkbox"/> Mass Transit <input type="checkbox"/> Gas Reimbursement	Height: _____ Weight: _____ Stairs (#) _____ Ramp at home: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Can the Member sign the driver's log? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will signature status be permanent? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please add any pick-up instructions for the driver: _____		

PICK-UP INFORMATION

Facility/Complex Name:	Phone #:
Address:	City, State Zip:

DROP-OFF INFORMATION

Facility/Complex Name:	Phone #:
Address:	City, State Zip:

Treatment Type: <input type="checkbox"/> Dialysis <input type="checkbox"/> Mental Health <input type="checkbox"/> Rehab <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Other _____	Ordering Party: Name: _____ Title: _____ Phone#: () _____ Fax#: () _____
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NAME: _____ SIGNATURE: _____ DATE: _____

* This form must be completed by the facility's professional staff working under the supervision of the licensed Provider overseeing the patients' treatment. Including, Social Worker, Administration Assistant, Clinical Nurse Specialist, Certified Nurse Midwife, registered Nurse, and other licensed providers. The licensed Provider must be knowledgeable of the patients' appointment schedule and transportation needs. And the staff must be capable of accurately completing the form.

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

"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."