Modivcare Solutions
4149 Highline Blvd. Suite 200
Oklahoma City, OK 73108

TRANSPORTATION REQUEST FORM

(For one time trip)
Must Be Submitted 3 Business Days Prior to the Appointment Day

Please Complete All Fields of Form or Trip Will Not Be Scheduled
FAX # 800-597-2091
PHONE # 800-435-1276

Facility:	Trip Requestor:	Today's Date:
Member Name (Last, First, MI)		Select One: 0 Transportation 0 Gas Reimbursement
Medicaid ID #		Special Needs:
DOB: _____/_____/_____	Escort: 0 Yes 0 No	
Requestor Phone #	Requestor Fax #	

LEVEL OF SERVICE:

0 Ambulatory 0 Wheelchair (Please Complete Next Section) 0 Stretcher (Please Complete Level of Service Form)

If Wheelchair, please complete: Member Weight:_____ Member Height:____ Stairs: 0 Yes 0 No If yes, how many? _____
Is the member able to transfer to a sedan vehicle: 0 Yes 0 No

GAS REIMBURSEMENT INFORMATION (Complete Only if Gas Reimbursement is Selected)

Driver Name: _____ Mailing Address:_____SSN:

PICK-UP INFO

Residence/Facility Name:	Member Phone #
Address:	City, State ZIP

DROP-OFF INFO

Facility/Complex Name:	Facility Phone #
Physician's Name:	Nature of Appointment/Type of Physician:
Address:	City, State ZIP
Appointment Time ____/____/___	Appointment time:_____ 0 AM 0 PM
Will Call? 0 Yes 0 No (If no, enter Return Time)	Return Time: 0 AM 0 PM

To be processed ALL fields MUST be completed and legible.
Failure do so could result in trip not being processed.
(Must be submitted 3 Business Days prior to the appointment day)

NAME: **SIGNATURE:** **DATE:**