LogistiCare Solutions LLC
545 N. Pleasantburg Drive,
Suite 202
Greenville, SC 29607

Standing Order Form for Regularly Scheduled/Repeating Appointments

Date: _____ **Medicaid Member's Name:** _____
Medicaid Number: _____ **Region/County:** _____ **Date Of Birth:** _____
Appointment Days: ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat
Start Date: _____ **Level of Service** ☐ Ambulatory ☐ Wheelchair **Weight:**_____
Requires: ☐ Escort ☐ Car Seat
Requested By: _____ **Relationship:** _____ **Phone Number:** _____
Patient's Condition: _____
Treatment Type: (e.g., C & A Day Treatment) _____
Treatment Procedure Code(s) (e.g.Y3018): _____, _____, _____, _____, _____
Facility Medicaid ID Number: _____

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Pick-Up and Destination Information

From: _____ **Street Address:** _____ **Bldg:** _____**Apt:** _____

City: _____ **Zip Code:** _____ **State:** _____ **Phone Number: ( )** _____

Directions: _____

Appointment Time: _____**AM/PM** **Pick-Up Time:** _____**AM/PM**

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Drop off at (Program Name): _____

Street Address: _____ _____ **Bldg:** _____**Apt:**_____

City: _____ **Zip Code:** _____ **State:** _____ **Phone Number: ( )** _____-_____

Physician's Name_____

Directions: _____
Return Pick-Up Time: _____**AM/PM** ☐ **ONE WAY** ☐ **ROUND TRIP**

Patient's authorization expiration date: _____
(e.g. initial authorization for C & A Day Treatment Y3018 is for 450 one hour treatments)

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I, the licensed physician or certified professional named above, acknowledge that I understand that transportation is provided to treatments which are Medicaid covered services and hereby declare under potential penalty of Medicaid Fraud to the best of my knowledge and belief the above referenced information is accurate.
Physician or Certified Professional Signature: _____

For LGTC use only

Recertified ( ) or terminated _____ on _____ by _____
Reason for recertifying/terminating the standing order: _____

PLEASE RETURN VIA FAX TO

Region 1 866-420-6253 **Region 2** 877-272-3939 **Region 3** 877-272-3990