modivcare

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

STANDING ORDER FORM

FAX# 877.813.5599

PHONE # 866.469.2824

		0 New 0 Update Existing
Member Name:	**Medicaid#:**	**DOB: __ /__ /__**
Facility Name:	**Phone#:**	**Fax#:**

APPOINTMENT INFORMATION

Days ☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun	**Appt. Time:** 0 **AMO PM** **Return Time:** 0 **AMO PM**	0Ambulatory **O** Cane **O** Walker/Rollator **O** Escort *(If Member resides ½ mile or less from a fixed route stop, he/she must use mass transit **unless** a mass transit restriction form is on file)* **Is Member DART Certified? YES NO**
	Start Date _____ End Date _____	**0** Wheelchair 0 Manual **0** Electric Is the member able to transfer to an ambulatory vehicle: **0** Yes **O** No *(Medical Necessity Form required for **all** wheelchair transport requests)*
	Weight: **Height:** **Stairs:**	**0** Stretcher **0** Oxygen ___ Liters 0 Isolation *(Medical Necessity Form required for **all** stretcher transport requests)*
	Treatment Type:	**Special Needs:**

PICK-UP INFORMATION

Facility/Residence:	**Address:**
City/State/Zip:	**Room/Apartment#:**
Phone#:	**Alt#:**

DROP-OFF INFORMATION

Facility Name:	**Address:**
City/State/Zip:	**Building Name:** **Suite#:**
Phone#:	**Physician / Department:**

Must be submitted 3 days prior to the first trip

NAME: **SIGNATURE:** **TITLE:**

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