modivcare

Standing Order Request Form
for Appointments Occurring 3 Days or More per Week

Utah Facility Department Fax: **877-637-9079** M – F 8:00 a.m. to 5:00 p.m.

Non-emergency medical transportation is **not** available for clients who can transport themselves without mileage reimbursement.

Client's Name: _____ DOB: ___-___-____ Gender: M__ F__ Medicaid # _____

Name of parent/guardian *(if applicable)*: _____ Phone ( ) ____- _____

Appointment Days: ( )Sunday ( )Monday ( )Tuesday ( )Wednesday ( )Thursday ( )Friday ( )Saturday

Start date: _____ Requested by: _____Relation to the member: _____Phone ( ) ____- _____

For ModivCare use only: Recertified: _____ Terminated: _____ Date: _____By:

Level of Service:

( ) **Ambulatory**: Can walk. ( )**Escorted** ( ) **Door to Door** ( ) **Curb to Curb**

( ) **Wheelchair**: Requires a lift-equipped wheelchair van ( )**Wheelchair**:Can transfer with out assistance

Other Medical considerations: _____ _____

Patient Condition: _____ Facility NPI #: _____ _____

Treatment Type: _____ Procedure Code(s): _____ _____

Can the client sign the Driver's Log? Yes: ___ No: ___ *If no, is client's inability to sign permanent?* Yes: ___ No: _____

Please explain if client's inability is permanent: _____ _____

Transportation provider currently transporting client:_____ Phone ( ) _____- _____

Pick Up: *Check if it's the person's home* ( ) *or a facility* ( ). *If a facility, please name it:*_____ _____

Please confirm the client's pickup address with the client as some clients change residence frequently.

Pick up street address:_____Bldg: _____Apt: _____

City: _____ State: _____ Zip:_____ Phone: ( ) _____- _____ Cell: ( ) _____- _____

Additional Instructions: _____

Appointment Time: __ _____ AM / PM Suggested Pick Up Time from Home: _____ AM / PM

Drop Off At: Facility Name:_____ Contact Name: _____ _____

Street address: _____ Bldg: _____Apt: _____

City: _____ State: _____ Zip:_____ Phone: ( ) _____- _____ Cell: ( ) _____ _____

Additional Instructions: Physician Name: _____

Return Pick Up Time: _____ AM / PM Please specify if trip is: One-way trip: ( ) or Round trip: ( )

Authorization: I request non-emergency medical transportation for the named client only for those days when the client will receive a covered service at the named facility. I affirm that the information above is accurate, and that I am a physician, physician's assistant, nurse midwife, or nurse practitioner, social worker.

Signature: _____ Date: ____-____- _____

Please print your name: _____ Phone: ( ) _____- _____

Reason for recertifying/terminating the standing order: _____

PLEASE FAX THE COMPLETED FORM TO THE UTAH FACILITY DEPT. at 877-637-9079