

VA Operations Reservations Call Center 798 Park Ave NW Norton, VA 24273 Phone: 866.679.6330

Fax: 866.679.6329

TRANSPORTATION REQUEST FORM

(For single date trip requests)

Must Be Submitted <u>5-Business Days</u> Prior to the Appointment Day
Trip Requests with Less Than a 5-Business Day Notice Must Be Called In
To be processed ALL fields MUST be completed and legible; failure to do so will result in the trip request being denied.

Facility:	Trip Request	tor:	Professional Title:
Requestor Phone # Requestor Fax		ax #	Trip Date:
Member Name (Last, First, MI)			ecial Needs: (Please include special equipment or pick-up/drop instructions)
DOB://		No	
Insurance Type:	Medicaid ID #		
	•		Car Seat (Member must provide car seat)
LEVEL OF SERVICE AND LEVEL OF ASSISTANCE:			
☐ Curb-To-Curb ☐ Door-To-Door ☐ Hand-To-Hand			
☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Bariatric Stretcher ☐ Stretcher Van			
Medical Condition that Requires Wheelchair or Stretcher:			
Weight: Height: Stairs(#): Wheelchair Type: □ Manual □ Electric (Height and Weight are Required for All Wheelchair, Stretcher and Stretcher Van Requests)			
Is the member able to transfer from his or her wheelchair, in and out of a vehicle safely: Yes No			
PICK-UP INFORMATION			
P/U Facility Name/Residence:	11011 01		Phone #
Address/Apt:		City, State ZIP	
DROP-OFF INFORMATION			
D/O Facility/Complex Name:			Phone #
Address/Suite:		City, State Zip:	
Appointment Time:		Will Call	☐ Yes ☐ No
☐ One Way or ☐ Round Trip		Return Time:	□ AM □ PM
Appointment Reason:		☐ Public Transit ☐ Mileage Reimbursement Does your facility provide its own transportation? ☐ Yes ☐ No	

"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."

NAME: ______ SIGNATURE: _____ DATE: _____