West Virginia Operations
Facility Department 602
Virginia St. E Charleston,
WV 25301

STANDING ORDER FORM

(Please fax to the number provided at least 5-days before the initial trip)
Fax: 855-882-5998 | Phone: 844-889-1941

Member's Name:	Insurance Type:	☐ New ☐ Update Existing
Member's Medicaid ID #:	Gender: Female / Male	DOB: ___/___/___

APPOINTMENT INFORMATION

Appointment Days ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐Saturday ☐Sunday	Appt. Time: _____ ☐ AM ☐ PM Return Time: _____ ☐ AM ☐ PM	Level of Service: (Please select the appropriate Level of Service) ☐ Ambulatory ☐ Wheelchair* ☐Mileage Reimbursement ☐ Public Transit *Member's condition that requires wheelchair:
	Start Date: ___/___/___	Height: Weight: **(Height and weight are needed for all wheelchair requests)**
	End Date: / /	Assistance Level: ☐ Hand-to-Hand ☐ Door-to-Door ☐ Curb-to-Curb
	Special Needs:	Can the Member sign the driver's log? ☐ Yes ☐ No Will signature status be permanent? ☐ Yes ☐ No **Requested Provider's Name *(not guaranteed)*:**

PICK-UP INFORMATION

Facility/Complex Name:	Phone:
Address/Apt:	City, State Zip:

DROP-OFF INFORMATION

Facility/Complex Name:	Phone:
Address/Suite:	City, State Zip:

Treatment Type: ☐ Adult Daycare ☐ Substance Abuse ❍ Behavioral Health ☐ Therapeutic Day TX ❍ Day Support ☐ Supported Employment ❍ Dialysis	**Requesting Party:** Name:_____ Title: _____ Phone: ( ) ___ Fax: ( )_____

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