For Discharges Requiring Inter-Island Travel - Email form to: AirOps@modivcare.com and DisPHXAfterhours@modivcare.com

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Request Form for Meals, Lodging and Commercial Travel

Return via email to: HIExceptions@modivcare.com
or fax form to: 1-866-475-5745

Health Care Coordinator Name: _____
Callers Name: _____
Date: _____
Time: _____
Prior Authorization: _____
PA# _____
Verified Appointment with: _____

Gas Reimbursement Needed: YES ☐ NO ☐
Ground Transportation Needed: YES ☐ NO ☐
Commercial Air Needed: YES ☐ NO ☐
Lodging Needed: YES ☐ NO ☐
Meal Reimbursement Needed: YES ☐ NO ☐

Member Demographics:

- Member's name: _____
- Member's ID: _____DOB: _____
- Member's telephone #: 1) _____2)_____
- Member's Level of Service- Ambulatory or Wheelchair: _____
- If Wheelchair what type:_____

Facility / Doctor's:

- Name: _____
- Address: _____
- Phone Number: _____
- Appointment/Admit Date: _____Time: _____
- Discharge Date (if inpatient): _____
- How many additional people will be traveling (excluding member): _____
- Name/Relationship to Member: _____

Lodging Requested:

- YES ☐ NO ☐
- Reimbursement ☐ **or** ModivCare Payment ☐
- Date lodging starts: _____Ends: _____
- Name of Facility / City: _____
  - Do you require an ADA room? YES ☐ NO ☐
  - Are you in a Wheelchair? YES ☐ NO ☐
  - Do you have any other special medical needs (i.e. refrigerator in room for insulin)?

    _____

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SPECIAL INSTRUCTIONS:

Commercial Air Request Information:

- YES☐ NO☐
- Departure City and Airport: _____
- Arrival City and Airport: _____
- Departure Date: _____
- Return Date: _____
- Medical Reason for Stay Longer than 1 day:_____
- Type of Ticket (One Way or Round Trip): _____
- Attendant Required YES☐ NO☐
- Medical Reason for Attendant: _____
- Name of Adult Attendant (As Listed on Valid Photo ID)
  _____ Date of Birth _____
  Gender: MALE☐ FEMALE☐
- Are you on oxygen? YES☐ NO☐

Prepaid Meals Requested:

- YES☐ NO☐
- Date meals start: _____End: _____

Note: Meals should correspond to lodging dates.

Health Plan/Care Coordination/Member Care staff: Please provide contact info for anyone other than traveling Member requiring receipt of the itinerary OR changes to the itinerary:

Name: _____ Email (or fax): _____

Name: _____ Email (or fax): _____

Medical Care Provider Information (Please ensure form is accurate and complete prior to signing)
I _____, the medical care provider (*such as: physician, physician assistant, nurse practitioner, or healthcare coordinator), have evaluated this member and certify that he or she is medically/functionally appropriate for the mode of transportation designated above. I hereby certify that all information provided by me in connection with this application, including any documents, attestations, or representations submitted, is true, complete, and accurate to the best of my knowledge. I understand and acknowledge that I am solely responsible for the authenticity and accuracy of all such information.

Name (printed): _____ Telephone: _____

Signature of Medical Provider: _____

Date: _____

****Per the Hawaii Revised Statutes HRS §489E-7, this electronic signature satisfies the law.*