STANDING ORDER REQUEST/CANCELLATION FORM

https://tripcare.modivcare.com/login

Member's Name:Click here to enter text.	Insurance Type:Click here to enter text.	
Member's Insurance ID#Click here to enter text.	Gender: ☐ Female ☐ Male	DOB: ____/___/___
Standing Order Request: ☐ **New** ☐ **Modifying**☐	Cancel Standing Order: ☐	Last Day Attended: _____

APPOINTMENT INFORMATION

Appointment Days ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	*Requested Time of Arrival: _____ ☐ AM ☐ PM	**Level of Service:** ☐ Ambulatory ☐ Stretcher ☐ ALS ☐ BLS ☐ Wheelchair* ☐ Mass Transit * Wheelchair - ☐ Manual ☐ Electric ☐ Bariatric (Oversized) Transferable ☐	
	*Requested Return Time: _____ ☐ AM ☐ PM		
	Start Date:____/_____/_____	Height: Click here to enter text. Weight:Click here to enter text.	
	End date:____/_____/_____	☐ Ongoing	☐ One Way ☐ Round Trip
	Special Needs: Click here to enter text.	Can the member sign the driver's log? ☐ Yes ☐ No	
		Will signature status be permanent? ☐ Yes ☐ No	

Dialysis-For requested time of arrival please include additional time needed for before and after chair time. Please refer to Dialysis transportation guidelines.

PICK-UP INFORMATION

Facility/Residential Name:Click here to enter text. Special Instructions:Click here to enter text. **Number of Steps** _____ ☐ **Ramp**	Phone #Click here to enter text.
Address/Apt:Click here to enter text.	City, State ZipClick here to enter text.

DROP-OFF INFORMATION

Facility/Complex Name:Click here to enter text. **Number of Steps** _____ ☐ **Ramp**	Phone #Click here to enter text.
Address/Suite:Click here to enter text.	City, State ZipClick here to enter text.

Treatment Type:	Ordering Party:
☐ Hemodialysis ☐ Adult Day Care ☐ Cancer Care ☐ Rehab ☐ Substance Abuse/Methadone ☐ Mental Health ☐ Physical Therapy ☐ Adult Day Support	Name:Click here to enter text. Title:Click here to enter text. Phone#: Click here to enter text. Fax#: Click here to enter text.

By submitting this form, I agree to cooperate with Modivcare's fraud, waste and abuse mitigation efforts and will provide attendance verifications reports and re-certifications of standing orders as reasonably requested.

Facility Staff Name: _____

Signature: _____ Date: _____