

STANDING ORDER REQUEST/CANCELLATION FORM

PLEASE FAX 855-397-3607

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	Height: Click here to enter text. Weight: Click here to enter text.	
	Start Date: ____/____/____		
	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 Zip Click 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 Zip Click here to enter text.

Treatment Type: ☐ Hemodialysis ☐ Adult Day Care ☐ Cancer Care ☐ Rehab ☐ Substance Abuse/Methadone ☐ Mental Health ☐ Physical Therapy ☐ Adult Day Support	Ordering Party: Name: Click here to enter text. Title: Click here to enter text. Phone#: Click here to enter text. Fax#: Click here to enter text.
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By submitting this form, I agree to cooperate with LogistiCare'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:** _____