Form SO (Rev. 4/16/2015)

# Standing Order Transportation Request Form

**For reoccurring appointments, same pick-up and drop-off times, at least once a month for 12 months, or 1 or more times per week for 4 or more weeks. Do not order transportation for enrollees who live within one-half mile of the medical facility and can walk there. Questions? Call us at 844-678-1106.**

Enrollee's Name: _____ DOB: ____-____-____ Gender: M__ F__ Medicaid #: _____

Appointment Days :( ) Sunday ( ) Monday ( ) Tuesday ( ) Wednesday ( ) Thursday ( ) Friday ( ) Saturday

**Start Date:** _____ Emergency Contact: _____ Relationship to Patient: _____ Phone: ( ) ___- _____

**Treatment type**: ADHC ___. Oncology Treatments ___. Dialysis ___. Mental Health ___. Rehab ___. Substance Abuse ___. Wound Care ___. Phy. Therapy ___ Other: (Specify) _____

PCA (Personal Care Attendant): ____ Adult: ___ Child: ___ Seats: ____

**Medically necessary mode of transportation:**

- ☐ **Public Transit:** The patient is able to utilize Public Transportation. **Form 2015 is not required for Public Transit.**
- ☐ **Livery:** The patient can get to the curb, board and exit the vehicle unassisted, or is a collapsible wheelchair user who can transfer without assistance **but cannot** utilize public transportation. **Attach completed Form 2015.**
- ☐ **Ambulette Ambulatory:** The patient can walk **but requires** assistance. **Attach completed Form 2015.**
- ☐ **Ambulette Wheelchair:** The patient is a wheelchair user, requires lift-equipped or roll-up wheelchair vehicle **and** assistance. **Attach completed Form 2015.**
  ***** Provide the Weight: _____ Height: _____ Manual or Motorized (Circle one) *****
- ☐ **Stretcher Van:** The patient is confined to a bed, cannot sit in a wheelchair, and ***does not*** require medical attention/monitoring during transport. **Attach completed Form 2015.**
- ☐ **BLS Ambulance:** The patient is confined to a bed, cannot sit in a wheelchair, **and requires** medical attention/monitoring during transport for reasons such as isolation precautions, oxygen not self-administered by patient, sedated patient. **Attach completed Form 2015.**
- ☐ **ALS Ambulance:** The patient is confined to a bed, cannot sit in a wheelchair, **and requires** medical attention/monitoring during transport for reasons such as IV requiring monitoring, cardiac monitoring, and tracheotomy. **Attach completed Form 2015.**

**Preferred Transportation Provider**: _____ Phone ( ) _____-_____

**Pick Up:** *Check if it's the person's home* ( ) *or a facility* ( ). *If a facility, please name it:* _____

Pick up street address: _____ Bldg.: _____ Apt/Floor/Suite: _____

City: _____ State: _____ Zip: _____ Phone: ( ) _____-_____ Cell: ( ) _____-_____

Directions: _____

**Appointment Time: _____ AM / PM** **Suggested Pick Up Time from Home: _____ AM / PM**

**Pick-up directions and/or patient special needs/ please indicate if a 2 man assist is necessary:** _____

_____

**Drop Off Information:**

Drop Off At (Facility Name): _____ Contact Name: _____

Street address: _____ Bldg.: _____ Floor/Suite: _____

City: _____ State: _____ Zip: _____ Phone: ( ) _____-_____ Cell: ( ) _____-_____

**Return Pick up Time: _____ AM / PM (Required) *****

**Drop-off directions (if any):** _____

**Expiration/End Date:** _____ **Max Trips:** _____ **Reason for Cancellation:** _____

**Facility Contact:** _____ **Phone: ( ) _____-_____ Fax: ( ) _____-_____**

**A valid, properly completed Medical Necessity Form (2015) justifying the mode of transportation indicated above must accompany this Standing Order Trip. All Standing Order trip requests submitted without the proper documentation will delay processing until all required documentation is received.**

**CERTIFICATION STATEMENT: I (or the entity making the request) understand that orders for Medicaid-funded travel may result from the completion of this form. I (or the entity making the request) understand and agree to be subject to and bound by all rules, regulations, policies, standards and procedures of the New York State Department of Health, as set forth in Title 18 of the Official Compilation of Rules and Regulations of New York State, Provider Manuals and other official bulletins of the Department, including Regulation 504.8(2) which requires providers to pay restitution for any direct or indirect monetary damage to the program resulting from**

**Fax to: 855-848-8640**