Single Trip Reservation Form- WellCare- MLTC
Amerigroup- MLTC - Medicare

Facility Department
P.O. Box 464, North Haven, CT 06473
Facility Line: 866–428–2351
Facility Fax: 877–457–3334

<u>*PLEASE COMPLETE ALL AREAS OF FORM OR TRIP WILL NOT BE SCHEDULED*</u>
(MUST BE SUBMITTED *<u>NO LATER THAN</u>* 48 HOURS PRIOR TO THE APPOINTMENT)

***Facility Name:** _____

***Person Requesting:** _____

<u>****Traveling with Aid/Comp: Yes or NO ******</u>**

****

***Patient/Client Name:**

***Last:** _____ **First:** _____ **Social Security #** _____

***Date of Birth:** ____/_____/_____ ***Medicaid ID #** _____-_____-_____

DSS Worker Name & Phone Number (if pending T-19) _____

***Phone: (** _____ **)** _____ **-** _____ **Fax #: (** _____ **)** _____ **-** _____

<u>TRANSPORT/APPOINTMENT</u>

APPOINTMENT TYPE/REASON:**_____DATE**: _____

APPOINTMENT TIME:** _____ESTIMATED RETURN TIME:** _____

CONFIRMATION #: _____**PICK-UP TIME:** _____

<u>*ALL BELOW INFORMATION IS REQUIRED. IF ANY FIELD IS LEFT BLANK NO RIDE WILL BE SCHEDULED.*</u>

***Pick-up Location* - Address:** _____ **Suite/Room. #** _____,

City/Town _____ **ZIP CODE** _____ **Phone: (** **)**_____-_____

***Drop-off Location*-Address:** _____ **Suite/Room#**_____

City/Town _____ **ZIP CODE**_____

Dr.'s Name _____ **Phone #: (** **)**_____-_____

Type of transportation requested: (select one):
<u>TRIP WILL BE SCHEDULED AS LIVERY IF LEVEL OF TRANSPORT NOT SELECTED</u>

Livery (Car)_____ **(Curb to curb service)**

Ambulette _____ **(Member has wheelchair). Medical reason:** _____

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Requested Provider _____