Single Trip Reservation Form

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

PLEASE COMPLETE ALL AREAS OF FORM OR TRIP WILL NOT BE SCHEDULED
(MUST BE SUBMITTED *NO LATER THAN* 72 HOURS PRIOR TO THE APPOINTMENT)

***Facility Name:** ___________________________________

***Person Requesting:** ____

********Traveling with Aid/Comp: Yes or NO ********

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***Patient/Client Name:**

***Last:** ___________________ **First:** ________________ **Social Security #** _______________

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

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

***Phone: (** _____ **)** _______ **-** __________ **Fax #: (** ______ **)** ________ **-** ___________________

TRANSPORT/APPOINTMENT

APPOINTMENT TYPE/REASON:**_________________DATE:** _______________________

APPOINTMENT TIME:** __________ESTIMATED RETURN TIME:** ________________

CONFIRMATION #: __________________**PICK-UP TIME:** _____________________

ALL BELOW INFORMATION IS REQUIRED. IF ANY FIELD IS LEFT BLANK NO RIDE WILL BE SCHEDULED.

***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):

TRIP WILL BE SCHEDULED AS LIVERY IF LEVEL OF TRANSPORT NOT SELECTED

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

Ambulette ________ **(Member has wheelchair). Medical reason:** _____________________________

Requested Provider ____