modivcare

MEDICAL TRANSPORTATION PROGRAM PARENT AUTHORIZATION FORM

Child's Name: _____ **Medicaid Number:** _____

Date of Birth_____ **Type of Program:** ☐ Medicaid ☐ CSHCN

My name is _____. I am the parent or legal guardian of the child named above. I have asked ModivCare to set up rides to get my child to and from health-care services covered by Medicaid or the CSHCN program. In the chart below I am listing facts about me and other adults I have chosen to be "attendants." These adults are authorized to go with my child to and from Medicaid or CSHCN covered health-care visits.

	First, middle, last name	Address	Phone number
Parent ☐ Guardian ☐			
Parent ☐ Guardian ☐			
Authorized Attendant 1			
Authorized Attendant 2			

It is my choice to authorize these people to be attendants. By signing this form, I am showing that I know the risk that go with allowing another person to travel with my child on health-care trips set up through ModivCare. I know this agreement will stay in effect until I change or replace it.

☐ **By signing below, I swear that, to the best of my knowledge, the authorized adults named above are not 1) the doctor or specialist providing the child's Medicaid services, 2) an employee of the Medicaid provider, or 3) someone paid by that provider.**

_____ _____

Signature of Parent or Legal Guardian Date

Two things must happen before the authorized attendants listed above can ride with the child to and from the covered health-care services;

1) This form must be on file with ModivCare or be given to the driver when the driver picks up the child for the health-care visit.
2) The authorized attendant also must show the driver a photo ID.

Fill out and mail this form to: Modivcare 12234 N IH 35, Bldg. B Suite 175, Austin, TX 78753

OR

Fill out and fax this form to: 1-855-864-0970