modivcare

Kansas Operations
4149 Highline Blvd. Suite 200
Oklahoma City, OK 73108

TRANSPORTATION REQUEST FORM

(For one time trip)
Must Be Submitted 3 Business Days Prior to the Appointment Day

Please Complete All Fields of Form or Trip Will Not Be Scheduled
FAX # 800-597-2091
PHONE # 866-697-0496

Facility:	Trip Requestor:	Today's Date:
Member Name (Last, First, MI)		Select One: ☐ Transportation ☐ Gas Reimbursement
Medicaid ID #		Special Needs:
DOB: _____/_____/_____	Escort: ☐ Yes ☐ No	
Requestor Phone #	Requestor Fax #	

LEVEL OF SERVICE:

☐ Ambulatory ☐ Wheelchair (Please Complete Next Section) ☐ Stretcher (Please complete Level of Service Form)

If Wheelchair, please complete: Weight:_____ Height:_____ Stairs? ☐ Yes ☐ No If yes, how many:_____

Is the member able to transfer to a sedan vehicle: ☐ Yes ☐ No

GAS REIMBURSEMENT INFORMATION (Complete Only if Gas Reimbursement is Selected)

Driver Name:_____ Mailing Address: _____ SSN:_____

PICK-UP INFO

Residence/Facility Name:	Member Phone #
Address:	City, State ZIP

DROP-OFF INFO

Facility/Complex Name:	Facility Phone #
Physician's Name:	Nature of Appointment/Type of Physician
Address:	City, State ZIP
Appointment Date: _____/_____/_____	Appointment Time ☐ AM ☐ PM
Will Call ☐ Yes ☐ No (If no, enter Return Time)	Return Time ☐ AM ☐ PM

To be processed ALL fields MUST be completed and legible.
Failure do so could result in trip not being processed.
(Must be submitted 3 Business Days prior to the appointment day)

NAME: _____**SIGNATURE:** _____ **DATE:** _____