MODIVCARE SOLUTIONS
TRANSPORTATION SPENDDOWN FORM

Member First and Last Name: ____________________

Member Home Address: ____________________

City: ____________ State: ____________ ZIP: ______

Member Phone Number: ____________ Trip Number: ____________

Appointment Date: ______ Appointment Time: ______ Round Trip? Yes No

Pick Up Address: ____________________

____

Destination Name of Doctor/Clinic/Facility: ____________________

Street Address: ____________________

City: ____________ State: ____________ ZIP: ______

Doctor/Clinic/Facility Telephone Number: ____________________

Total Miles: ____________________

Name of Transportation Company: ____________________

Address of Transportation Company: ____________________

Telephone Number of Transportation Company: ____________________

Medical Provider's Signature: ____________________ Date: ______

Driver's Signature: ____________________ Date: ______

Member's Signature: ____________________ Date: ______

Return **completed** form to:
Modivcare Solutions
Fax: 1-866-355-7340

MODIVCARE SOLUTIONS WILL RETURN ALL INCOMPLETE FORMS

FOR OFFICE USE ONLY			
Medicaid Number:	______	Date of Birth:	______
MCO:	______	ICN Number:	______
Treatment Type:	______		