Transportation Request Form

Fax to: 618-942-3109
Toll Free: 844-220-1243
Local : 618-215-3761

Date: _____

Time: _____

Contact Information

Your Name: _____Your Company: _____

Your Phone: _____Ext._____Your Fax: _____

Patient Information

Name: _____ Sex: _____ Date of Birth: _____

Address: _____

Home Phone: _____Cell Phone: _____

Alternate Contact Name/Phone (Family Member, Friend): _____

Insurance Name: _____Insurance/Medicaid ID Number: _____

Medical reason for travel: _____

Referring Physician Name: _____ Phone Number: _____

Payment source: ☐ Medicaid ☐ Private Insurance ☐ Patient (self pay) ☐ Healthcare Provider ☐ Other_____

Appointment Information

Name of Physician the Patient is Seeing: _____ Phone: _____

Appointment Date: _____ Appointment Time: _____

Pickup Information

☐ Home ☐ Doctor's Office: _____ ☐ Facility: _____

Pickup Address: _____

Assistive Device: ☐ Wheelchair ☐ Walker ☐ Scooter ☐ Other: _____ Escort Traveling with Patient? ☐ Yes ☐ No

Is wheelchair more than 30" wide or 48" long? ☐ Yes ☐ No Can patient transfer in/out of wheelchair? ☐ Yes ☐ No

Does the combined weight of the patient and the wheelchair/scooter exceed 600 pounds? ☐ Yes ☐ No

Drop-off Information

☐ Home ☐ Doctor's Office: _____ ☐ Facility: _____

Drop-off Address: _____

Will patient need a return ride? ☐ Yes ☐ No If yes, time of pickup: _____

Return to: ☐ Original pickup location ☐ New location Escort Traveling with Patient? ☐ Yes ☐ No

If new location: ☐ Home ☐ Doctor/Facility Name: _____ Phone: _____

Drop-off Address: _____

Additional Comments: _____

For Rides Plus use only

Mobility Specialist: _____ Date: _____ Time: _____ Trip #: _____