Transportation Request Form
Fax to: 618-942-3109
Phone: 844-220-1243

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: ____

Does the patient use a Mobility Device: ◯ Yes ◯ No If Yes, please specify type of device: ________________________

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Is someone traveling with the patient to assist him/her? ◯ Yes ◯ No If Yes, name: _____________________________

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 ◯ Home ◯ New Location

If New Location: Doctor/Facility Name: _____________________________________ Phone: _______________________

Drop-off Address: ____

Additional Comments: ____

For Rides Plus use only

Mobility Specialist: _________________________________ Date: ___________ Time: ___________ Call #: __________