



MEDICAID TRANSPORTATION REQUEST

Fax Completed Form to 315-299-2786

TO: Medicaid Transportation, 375 W. Onondaga St. #15, P.O. Box 11998, Syracuse, NY 13218

FROM: _____ at _____
Phone #: (____) _____ - _____ Fax #: (____) _____ - _____

DATE COMPLETED: ____/____/____

Client Name: _____ Sex: Male or Female
Medicaid # _____ DOB: ____/____/____ Client's Phone #: (____) _____ - _____

Pickup Address: _____

Drop off Address: _____

Medicaid or Title XX(Services Case) Client's Phone #: (____) _____ - _____

Pickup/Start Date: __/__/__ Pickup Time: _____

Reason for Trip (s) _____

Transportation Vendor: _____

Appt. Time: _____

Round Trip: Yes or No, If "Yes" approx time of return pickup: _____

Standing Order: Yes or No, If "Yes" days of week M Tu W Th F Sa Su

Addition to Standing Order: Yes or No

Transp. Mode: Bus Taxi Wheelchair Ambulatory Staff

wheelchair, does client Have or Need a wheelchair

Client's medical provider: _____ Medicaid Provider NPI#: _____

Special Instructions: _____
