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 ☐ Stretcher

If wheelchair, does client ☐ Have or ☐ Need a wheelchair

Client’s medical provider: ___________________________ Medicaid Provider NPI#:____________

Special Instructions: ________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

If you any questions regarding this form, or any Medicaid Transportation Prior Approval request, please call Medical Answering Services, LLC at 315-701-7551. Please destroy all previous versions of this form.

Revised 01/23/2012