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 □ S □ Su

Addition to Standing Order: □ Yes or □ No

Transp. Mode: □ Bus □ Taxi □ Wheelchair □ Ambulatory □ Stretch

    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 12/14/2017