Standing Order Transportation Request Form

Reoccurring appointments with same pick-up and drop-off times, at least once a month for 6 months, or 1 or more times per week for 4 or more weeks.

Member's Name: _____ DOB: ___/___/_____ Gender: M ☐ F ☐

Medicaid ID Number:_____

Member's Phone Number:(___)_____

Alternate Phone Number:(_____) _____

Requestor's Name:_____

Requestor's Relationship to Patient: _____

Requestor's Contact Number: (____) _____ Requestor's E-mail _____

Appointment Reason: _____

Appointment Time: _____

Return Pickup Time: _____

Appointment Start Date:_____ End Date: _____

Appointment Days of week (Circle all that apply): Sun Mon Tues Wed Thurs Fri Sat

Member's Mobility Type (Choose One): ☐ Ambulatory ☐ Manual W/C ☐ Motorized W/C ☐ BLS ☐ ALS

Notes/Comments:_____

Home/Pickup Address:_____Bldg.:_Apt/Floor/Suite:___

City:_____ State:_____ Zip:_____

Special Directions: _____

Facility/Dropoff Address:_____Bldg.:_____Apt/Floor/Suite:___

City:_____ State:_____ Zip:_____

Special Directions: _____ Facility Phone Number: _____

☐ The member lives ¼ of a mile from the bus stop, and the facility is ¼ a mile or less, and the member can physically walk to from the bus stop before and after appointments. (In this case a monthly bus pass will be issued for the member)

☐ The Member has a friend or family member that is willing to bring them to/from the appointments and be reimbursed through the Gas Reimbursement Program.

☐ The Member does not qualify for Public Transit or Gas Reimbursement

Please sign below that the above information is accurate and true to the best of your

knowledge. Requestors Signature: _____

Please submit all completed Standing Order forms to MediTrans via email at

facility@callmeditrans.com or fax at (337) 366-6760