Modivcare Solutions
2602 S 47TH ST
Phoenix AZ 85034

NM BCBS CENTENNIAL TRANSPORTATION REQUEST FORM

(For one time trip)
Must be submitted within 72 hours prior to the appointment date
Please complete all fields on the form or trip will not be scheduled
FAX # 866-402-0522
PHONE # 866-400-8233

Facility Name:	Trip Requestor:	Date of Trip:
Member's Name (Last, First, MI)		Insurance Type:
Medicaid ID #		Special needs:
DOB: ____/____/____	Escort: ❑ Yes ❑ No	
Phone #	Fax #	

LEVEL OF SERVICE:

❑ Ambulatory ❑ Wheelchair ❑ Stretcher ❑ Gas Reimbursement ❑ Mass Transit

If Stretcher provide precautions:

Wheelchair/Stretcher: Please provide the following information

Type of Wheelchair: ❑ MANUAL ❑ ELECTRIC ❑ SCOOTER ❑ N/A

Weight: Height: Stairs:(how many steps): Ramp: ❑ Yes ❑ No

Is the member able to transfer to a sedan vehicle: ❑ Yes ❑ No

PICK-UP INFO

Facility Name/Residence:	Phone #
Address:	City, State ZIP

DROP-OFF INFO

D/O Facility/Complex Name:	Phone #
Address/Suite:	City, State, ZIP
Requested Pick Up Time ❑ AM ❑ PM	Return Time: ❑ AM ❑ PM **OR**
Appointment Time ❑ AM ❑ PM	Will Call ❑ Yes ❑ No
❑ One Way or ❑ Round Trip	

In order to be processed ALL fields MUST be completed and legible. Failure do so could result in trip Not being processed
(Must be submitted 72 hours prior to the appointment day)

NAME (Please Print):_____ **SIGNATURE:** _____ **DATE:**