modivcare

Standing Order Request Form
for Appointments Occurring 2 Days or More per Week

Utah Facility Department Fax: **877-637-9079** M – F 8:00 a.m. to 5:00 p.m.

Non-emergency medical transportation is **not** available for clients who can transport themselves without mileage-reimbursement.

Client's Name: _____ DOB: ___-___-____ Gender: ☐ M ☐ F Medicaid # _____

Name of parent/guardian *(if applicable)*:_____ Phone ( ) ____- _____

Appointment Days: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Start date:_____ Requested by: _____ Relation to the member: _____Phone (____) _____- _____

Level of Service:

☐ **Ambulatory**: • Can walk, or • Can transfer out of wheelchair without assistance ☐ **Escorted** ☐ **Door to Door** ☐ **Curb to Curb**

☐ **Wheelchair (W/C)**: Requires a mobility vehicle/wheelchair van for transport ☐ **Manual W/C** ☐ **Electric Wheelchair**

Other Medical considerations: _____

Patient Condition: _____ Facility NPI #: _____

Treatment Type:_____Procedure Code(s): _____

Can the client sign the Driver's Log? ☐ Yes ☐ No: *If no, is client's inability to sign permanent?* ☐ Yes ☐ No

Please explain if client's inability is permanent: _____

Transportation provider currently transporting client: _____ Phone (____) _____ _____

Pick Up: *Check if it's the person's home* ( ) *or a facility* ( ). *If a facility, please name it:* _____

Please confirm the client's pickup address with the client as some clients change residence frequently.

Pick up street address: _____Bldg: _____Apt: _____

City: _____State: _____ Zip: _____ Phone: (_____) _____ - _____ Cell: (_____) _____ - _____

Additional Instructions:_____

Appointment Time:_____ AM / PM Suggested Pick Up Time from Home:_____AM / PM

Drop Off At: Facility Name: _____ Contact Name: _____

Street address: _____Bldg: _____ Apt: _____

City: _____ State: _____ Zip: _____Phone:(_____) _____ - _____ Cell: (_____) _____ - _____

Additional Instructions: _____Physician Name: _____

Return Pick Up Time: _____ AM / PM Please specify if trip is: ☐ One-way trip or ☐ Round trip

Authorization: I request non-emergency medical transportation for the named client only for those days when the client will receive a covered service at the named facility. I affirm that the information above is accurate, and that I am a Physician, Physician's Assistant, Nurse Midwife, Nurse Practitioner, Social Worker, Admin Assistant, or Registered Nurse.

Signature: _____Date: ____-____- _____

Please print your name: _____ Phone: (____) _____- _____

For Modivcare use only: ☐ Recertified ☐ Terminated Date: _____ By: _____

Reason for recertifying/terminating the standing order: _____

PLEASE FAX THE COMPLETED FORM TO THE UTAH FACILITY DEPT. at 877-637-9079