Medicaid Transportation Request Fax Form

Questions? Contact LogistiCare Facility Services Dept.: 2 Huntington Quadrangle., Melville, NY 11747, Phone: 844-678-1106

Cover Page

Use this form when the ***VERIFICATION OF MEDICAID TRANSPORTATION ABILITIES*** (Form 2015) has already been submitted, *or* will be faxed separately, to LogistiCare.

_____
Date

_____ _____ _____
Physician's Name (PRINT) NPI# Telephone #

_____ _____
Name of the medical practice, hospital or clinic Medical Practitioner's Address

_____ _____
Name of the requested transportation company (not required, if you have no preference) Transportation Provider's Identification Number

_____ _____ _____
Indicate name of nurse/social worker or other person who completed this form Title Telephone #

Fax three days prior to appointment: **855-848-8640**

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Enrollee Name	Enrollee's Pick-up Address	Enrollee Medicaid ID Number	Enrollee's Phone Number	Required Level of Transportation Service	Appointment date	Appointment time	Return trip time, or will call (w-c), when ready?	Justification Form 2015 To Be Faxed? (Y/N)

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