Nassau and Suffolk County Medicaid Trip Order Form from One Medical Practitioner

Referring an Enrollee to Second Medical Practitioner

Questions?: Contact the LogistiCare Facility Services Department 844-678-1106

Trip Date: _____ **Appointment Time:_____** **Pick-Up Time:____:_____ AM/PM** **Return Time:____:_____ AM/PM**
(If return time is unknown, enter 23:59)

Preferred Transportation Provider: _____

□Public Transit □Livery □Ambulette Ambulatory □Ambulette Wheelchair □Stretcher □BLS Ambulance □ALS Ambulance

Enrollee Name:_____ Medicaid ID Number: _____

Enrollee Pick-up Address:_____ Phone Number:_____

Destination Facility:_____ NPI#:_____ Phone Number:_____

Address:_____

Destination Physician's Name: _____

CERTIFICATION STATEMENT: I (or the entity making the request) understand that orders for Medicaid-funded travel may result from the completion of this form. I (or the entity making the request) understand and agree to be subject to and bound by all rules, regulations, policies, standards and procedures of the New York State Department of Health, as set forth in Title 18 of the Official Compilation of Rules and Regulations of New York State, Provider Manuals and other official bulletins of the Department, including Regulation 504.8(2) which requires providers to pay restitution for any direct or indirect monetary damage to the program resulting from improperly or inappropriately ordering services. I (or the entity making the request) certify that the statements made hereon are true, accurate and complete to the best of my knowledge; no material fact has been omitted from this form.

_____ Referring Physician's Name (PRINT)

_____ NPI#

_____ Date

_____ Telephone #

_____ Name of the referring medical practice, hospital or clinic

_____ Referring Medical Practitioner's Address

_____ Indicate name of nurse/social worker or other person who assisted in completing this form

_____ Title

_____ Telephone #

_____ Referring Physician's Signature

Fax three days prior to appointment –855-848-8640