# Back Dated Trip Request Form

Enrollee's Name: _____ DOB: ____-____-____ Gender: M__ F__ Medicaid #: _____
Appointment Days: ( ) Sun ( ) Mon ( ) Tue ( ) Wed ( ) Thurs ( ) Fri ( ) Sat

Start date _____

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Level of service: ( ) **Ambulatory**/Livery ( ) **Ambulette**/requires driver's assistance walking ( ) **Wheelchair**

( ) **Stretcher:** The enrollee is confined to bed, cannot sit in a wheelchair but doesn't require medical assistance during transport.

( ) **BLS Ambulance:** The enrollee is confined to bed, cannot sit in a wheelchair, and requires medical attention/monitoring during transport.

**Transportation Provider**: _____ Phone ( ) _____-_____

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

Pick up street address: _____ Bldg: _____ Apt: _____

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

Directions: _____

**Appointment Time:** _____ **AM / PM**

**Special needs:** _____

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## Drop Off Information:

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

Street address: _____ Bldg: _____ Apt: _____

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

Directions: _____

**Return Pick Up Time:** _____ **AM / PM**

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Directions: _____

**Return Pick Up Time:** _____ **AM / PM**

Fax to: **844-678-1110.**