



Standing Order Request Form For Appointments Occurring 3 Days or More per Week

Texas Facility Department: Phone: 855-933-6998 Fax: 855-848-8643 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: () **Bus**. Bus stops are within ¼ mile of residence & ¼ mile of the medical provider. Client can walk ¼ mile.
 () **Gas Reimbursement** () **Client uses Volunteer Driver** _____
 () **Ambulatory**. Client can walk.
 () **Wheelchair**: Client cannot walk, is confined to a wheelchair & requires a lift-equipped wheelchair van.
 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: () ____-____
 Directions: _____
 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: () ____-____
 Directions: _____ 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 or social worker.
 Signature: _____ Date: ____-____-____
 Please print your name: _____ Phone: () ____-____

For LGTC use only: Recertified: _____ Terminated: _____ Date: _____ By: _____
 Reason for recertifying/terminating the standing order: _____

PLEASE FAX THE COMPLETED FORM TO THE TEXAS FACILITY DEPT. at 855-848-8643