

TRANSPORTATION REQUEST FORM
(For one time trip)

**MUST BE SUBMITTED 2 BUSINESS DAYS (48 HOURS) PRIOR TO THE APPOINTMENT DAY
PLEASE COMPLETE ALL FIELDS OF FORM OR TRIP CAN NOT BE SCHEDULED**

FACILITY NAME							
PERSON REQUESTING TRIP:							
PHONE:				POSITION;			
MEMBER INFORMATION		Last Name			First Name		
TUFTS ID #				DATE OF BIRTH		___/___/___ (MM/DD/YY)	
PHONE #		FAX #		ESCORT		<input type="checkbox"/> YES <input type="checkbox"/> NO	
TYPE OF TRANSPORTATION REQUESTED (select one)							
***WE ARE NOT ABLE TO SCHEDULE TRANSPORTATION IF LEVEL OF SERVICE IS NOT SELECTED							
<input type="checkbox"/> AMBULATORY <input type="checkbox"/> WHEELCHAIR <input type="checkbox"/> DOOR-DOOR NEEDED: Y N REASON: _____ <input type="checkbox"/> NON-MEDICAL STRETCHER <input type="checkbox"/> ALS <input type="checkbox"/> BLS SPECIAL NEEDS/EQUIPMENT SUPPLIES _____							
For Wheelchair/Stretcher Transports: Height _____ Weight: _____ Stairs: _____							
DATE OF SERVICE				INSURANCE			
PICK-UP INFO							
FACILITY/RESIDENCE NAME				SUITE/ROOM/APT #			
ADDRESS							
CITY				STATE		ZIP	
PHONE				APPOINTMENT TIME		<input type="checkbox"/> AM <input type="checkbox"/> PM	
DROP-OFF INFORMATION							
FACILITY NAME:							
ADDRESS				SUITE / ROOM/APT #			
CITY				STATE		ZIP	
PHONE				DR.'S NAME/DEPT			
PICK-UP/RETURN TIME		<input type="checkbox"/> AM <input type="checkbox"/> PM		**TREATMENT TYPE:		WILL CALL <input type="checkbox"/> YES <input type="checkbox"/> NO	

To be processed, **ALL** fields **MUST** be completed and legible. Failure do so could result in trip not being processed
Please fax complete form to: ((855) 864-0954
Facility Phone: (855)-483-6530