SOUTHEASTRANS
DRIVING THE FUTURE OF TRANSPORTATION MANAGEMENT

West Region TN

Standing Order Form

This form MUST be completed IN FULL and returned to Southeastrans within 5 business days of the first transport. Please FAX this form to your Southeastrans Inc. Standing Order Representative_ to (423) 370-1422. By completing this transportation request, I do hereby declare, under penalty of State and Federal Medicaid guidelines, that the information indicated on this form is true and accurate.

Submitter's Information — Date of Submission:

Name of Healthcare Worker Completing Form (Please Print)		Phone and Fax Number	
Healthcare Worker's email		Healthcare Title	
Healthcare Workers Signature (**required**):			

Member's Information

Member's Name			Telephone Number	
Street Address			Apartment Number/ Apartment Name	
City		TN	Zip Code	
"M" Number		Soc. Sec. Number	- -	☐ Female ☐ Male
Date of Birth	/ /	Emergency Contact Name & Phone Number		
☐ New ☐ Renewal ☐ Change				

Transport Information

Pick-up From (Residence)		Address				***(Include Apt/Room No.)***
City		TN	Zip		Telephone Number	
Transport To (Facility Name)		Address				
City		TN	Zip		Telephone Number	
☐ One Way Transport		☐ Round Trip Transport				

Treatment Information

Purpose of Appointment and CPT Codes **(Required - Please be specific)**					
First Date of Service		Duration of Treatment	**(Write Number)**	☐ Weeks ☐ Months	
Appointment Time		AM PM	Return Pickup Time		AM PM
Appt Days	Mon Tue Wed Thu Fri Sat			(Circle All That Apply)	

Mobility Information

☐ Ambulatory ☐ W/C ☐ Electric W/C ☐ Oversize W/C ☐ Stretcher ☐ Escort Required		
Can this Member use public transportation?	☐ No ☐ Yes	If no, why?

The purpose of this form is to gather information to insure that the requested services being provided to BlueCare members are within the guidelines established by both Federal and State Medicaid Agencies. **STATEMENTS ON THIS DOCUMENT ARE MADE UNDER THE PENALTY OF STATE AND FEDERAL MEDICAID FRAUD GUIDELINES.** Southeastrans reserves the right to verify the information provided on this form by site visits, patient and employee interviews, and other methods. Any discrepancies found will be reported to the appropriate State and Federal Medicaid Fraud Control Units. This together with any attachments is intended only for the use of the individual or entity to which it is addressed. It may contain information that is confidential and prohibited from disclosure. If you are not the intended recipient, you are hereby notified that any dissemination or copying of this form or any attachment is strictly prohibited. If you have received this message in error, please notify the original sender immediately by telephone or by returning this form.