

Louisiana Standing Order Request Form

This form must be completed in full and returned to Southeastrans within 5 business days of the first transport. Please fax to 225-410-7452. Please remember that you are responsible for informing Southeastrans of changes (Address, Phone Number, Time and Days) or cancellation of treatment. You will also be asked to recertify orders every six (6) months for Dialysis standing orders and every three (3) months for all others to avoid cancellation of the standing order. If you have any questions, please call the Southeastrans Facility Line at 1-855-325-7576.

Member Name _____	Medicaid Number _____
Member's Complete Address: _____	
Member's Phone () _____	Alt Phone () _____
Emergency Contact _____	Phone #: () _____

DOB / / Gender M or F CPT Code _____	Treatment _____
FACILITY NAME: Phone #: _____	
START DATE / / Days of the Week: S M T W TH F S (circle all that apply)	
Duration of Treatment: Special Instructions: _____	
START TIME _____ am/pm	END TIME _____ am/pm
Member's Mobility (circle one): Amb W/Chair Electric W/C Stretcher BLS ALS Bariatric	

Pick-Up Address: _____	Phone #: _____
Drop Off Address: _____	Phone #: _____
Circle One: Round Trip One Way	
Alternate Return Address: _____	
Is Member able to use Public Transit or Gas Reimbursement? (Circle one) Public Transit or Gas Reimbursement	
Driver's Name: _____	Phone #: _____ SSN #: - -
Complete Address: _____	

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.

Requestor Name: Phone: () _____