Date completed ____________________________

SOUTHEASTRANS

DRIVING THE FUTURE OF TRANSPORTATION MANAGEMENT

SSR ____________________________________
Provider Assigned ____________________________
Eligibility Verified ____________________________

Indiana 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 317-642-0913**. 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 1-855-325-7588.**

Member Name____ **Medicaid Number** ______________________

Member's Complete Address:____

Member's Phone (   )___________________________ **Alt Phone (   )**______________________________

Emergency Contact ___________________________________ **Phone (   )**____________________________

DOB ____/____/ ____ **Gender** M or F **CPT Code** _______________ **Treatment**______________________

Please check one **NEW** ☐ **CHANGE** ☐ **RECERTIFY** ☐

FACILITY NAME: ______________________________________ **Phone #:** _________________________

START DATE ______/_______/______ **Days of the Week: S M T W TH F S (circle all that apply)**

Special Instructions: ____

START TIME _______________ am/pm **END TIME** _______________ am/pm

Member's Mobility (circle one): Ambi W/Chair Electric W/C BLS* ALS* Bariatric BLS Bariatric ALS (requires additional attendant)

*** BLS and ALS will require a completed Letter of Medical Necessity (LMN).**

Pick-Up Address: ____ Phone #:_________________

Drop Off Address: ____ Phone #: _________________

Circle One: Round Trip One Way

Alternate Return Address: ____

Is Member able to use Public Transit? (Circle one) Yes or No

If no, member will be required to have a Public Transit Restriction Form on file.

Current Transportation Provider (if known) ____

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: (   )** ___________________

MDW