SOUTHEASTRANS

DRIVING THE FUTURE OF TRANSPORTATION MANAGEMENT

Date Completed_____
SSR_____
Eligibility Verified____

Arkansas New 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 501-217-1618. 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.

Member Name_____ **Medicaid Number** _____

Member's Complete Address:_____

Member's Phone ( )_____ **Alt Phone ( )**_____

Emergency Contact _____ **Phone ( )**_____

DOB ____/____/ ____ **Gender** M or F **CPT Code** _____ **Treatment**_____

I do hereby certify that I have **no other means of transportation** available within my household to attend the facility identified on this form. ** Required** Must be signed by Medicaid Member or Legal Representative.

Signed:_____ Date: _____

FACILITY NAME: _____ **NPI #:**_____ **Phone #:** _____

START DATE _____/_____/_____ **Days of the Week: 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: Ambi W/Chair Oversized or Electric W/Chair Attendant Needed Needs Car seat

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: ( )** _____