Standing Order Form

This form must be completed in its ENTIRETY and returned to Southeastrans within 5 business days of the first transport. Please email this form to Southeastrans Inc. at standingorder@southeastrans.com or **eFax number: (404) 420-2954** **Submitted Date:**

Name of Healthcare worker completing Form (please print)		Phone number AND Fax	
Healthcare worker's email		Healthcare Title	

Attestation of Need for Transportation

I do hereby certify that I have **no other means of transportation** available within my household to attend the facility/ program identified on this form. I understand that falsification or misrepresentation of any information may result in denial of Medicaid Non-Emergency Transportation Services or termination of current transportation services.

Medicaid Member or Legal Representative Signature (required): X_____

Member's Information

Member's Name			Telephone Number	
Street Address			Apartment Number Apartment Name	
City		**GA**	Zip Code	
Medicaid Number		Date of Birth		☐ Female ☐ Male
Emergency Contact Name			Emergency Contact Phone Number	

☐ New ☐ Renewal ☐ Change ☐ Public Transportation Provider Name: _____

Transport Information

Pick -Up From				Address (w/Apt. #)		
City		**GA**	Zip		Telephone Number	
Transport to				Address		
City		**GA**	Zip		Telephone Number	

☐ **ROUND TRIP TRANSPORT** ☐ **One Way TRIP TRANSPORT**

Medicaid Waiver Information

Medicaid Waiver Program ☒ **NO**

Treatment Information

Purpose of Appointment / CPT Codes (Required. Please be specific)					
First Future date of Service			Duration of Treatment		**MONTHS**
Appointment Time			Return Pickup Time		
Appointment Days	☐Mon ☐Tue ☐Wed ☐Thu ☐Fri				

Mobility

☐Ambulatory ☐W/C ☐Electric WC ☐ Oversize W/C ☐Stretcher **Height: (____' ____")** **Weight (____lbs.)**
Escort Required ☐

Please review the questions below regarding Public Transportation and answer all:

Can this Member use Public Transportation?	***Yes***	***No***
If not, can this member use Public Paratransit? (Door to door service)	***Yes***	***No***
Does this member need training to use Public Transit? *Our travel training team can assist members with challenges due to handicaps or unfamiliarity with the service.*	***Yes***	***No***

If you have answered NO to all above, please describe member's condition that prevents the use of public transit:

Under contract with the Georgia Department of Community Health, Southeastrans, Inc. is the Georgia Medicaid Non-Emergency Transportation Broker for the member referenced. The purpose of this form is to gather information to ensure that the requested services being provided to the Medicaid Members of Georgia 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.