FACILITY FAX RIDE REQUEST FORM

Paratransit Services

An HCA/Medicaid HIPAA Business Associate
4810 Auto Center Way
Bremerton, WA 98310
Phone: 855-553-0355
Fax: 360-373-0502 or 360-377-1528

Facility Name: _____
Facility Address: _____
Name of requestor: _____
Phone number: _____
Fax number: _____

Client Information:

Last Name: _____ First Name: _____ Date of Birth: _____

Medicaid Applehealth ProviderOne#: _____ Phone number(s): _____

Is client able to walk? YES☐ NO☐ Will they be using a cane☐ crutches☐ walker☐ knee scooter☐
Other: _____

Will client be using a standard size wheelchair/scooter up to 33" wide? YES☐ NO☐

If not standard size (33"), what are the dimensions of the wheelchair or scooter? _____

Is client able to transfer out of the WC/Scooter? YES☐ NO☐ Does the WC fold? YES☐ NO☐

Combined weight with client and chair – less than 300lbs☐ or greater than 300lbs☐

Will the client be traveling alone? YES☐ NO☐ Special Needs (if any): _____
If a child will be in the vehicle, do they have their own infant, car or booster seat? YES☐ NO☐

Appointment Information:

Date of the appointment: _____ Check-in Time: _____ Return time: _____

Is this a repeating appointment? If so, list additional dates within the next 30 days:

_____

Pickup Address: _____ Apt#:_____ City: _____ Zip Code: _____

Appointment Address: _____ Suite/Floor:___ City: _____

Name of professional they are seeing (Dr, Arnp, Cnslr, etc): _____
Phone Number: _____

Appointment type (dialysis, dental, drug&alcohol, laboratory, mental health, primary care, radiology, specialty, Vision, etc) _____

Reason for appointment – if seeing a specialist, must also provide type of specialty - FYI cannot just state follow up or imaging – need specific information – follow up on what? If for imaging - what type and body part, If for PT or OT - which one and what body part is being treated, If for labs - what type of lab, etc. Need enough information to help determine a Medicaid billable service is taking place:

_____

Referring Doctor Name – phone & fax number (if applicable):

_____

Have we assisted with transportation to this appointment before? YES☐ NO☐
Is this a telemed/telehealth appt? YES☐ NO☐