Transportation Request Form

Attention:
Please fax completed form to MTM's Contact Center at 636.561.6055

Please complete this form in its entirety. Note: Three (3) business days' notice is required for standard transportation requests. Urgent appointment requests or changes with less than 72 hours' notice must be made by phone.

Person Making Request:		**Date:**	
Phone:		**Fax:**	
Patient Last Name:		**Patient First Name:**	
Phone:	**Medicaid ID Number:**	**Date of Birth:**	
Appointment Type:		**Round Trip?** ☐ Yes ☐ No	
Pick-up Street Address:	**City:**	**State:**	**Zip:**
Additional Passenger? ☐ No ☐ Yes	**Additional Passenger Name:**	**Additional Passenger Age:**	
Destination Name (Facility/Practice/Doctor):	**Destination Phone:**	**National Provider ID (NPI):**	
Destination Street Address:	**City:**	**State:**	**Zip:**
Appointment Date:	**Appointment Time:**		
Patient's Weight:	**Number of Steps:**	**Does patient require a stretcher?** ☐ No ☐ Yes (*a LON may be required)*	
Does patient use any of the following assistive devices? ☐ Scooter ☐ Electric Wheelchair ☐ Manual Wheelchair		**Can patient transfer into a car?** ☐ No ☐ Yes	
If requesting trip with less than required days notice, please list reason for urgency:			

Is this a recurring trip? ☐ Yes ☐ No	**Recurring Trip Start Date:**	**Recurring Trip Stop Date:**
	What is the weekly schedule? ☐ N ☐ M ☐ T ☐ W ☐ R ☐ F ☐ S	
	Appointment Start Time:	**Appointment Completion Time:**

Special Needs or Remarks (Preferred transportation provider, etc):