



MEDICAL TRANSPORTATION – ASSISTANCE REQUEST

NAME: _____ MEMBER ID: _____

D.O.B.: _____ CASE MANAGER NAME: _____

FORM TO BE COMPLETED BY PHYSICIAN:

_____ is requesting assistance with medical travel and transportation.
(PATIENT'S NAME)

Please briefly detail the patient's medical condition:

Please specify the nature of the necessary appointments:

Please state the frequency: _____ / week **OR** _____ / month

Patient is required to attend these appointments for the next _____ month(s).

Patient is able to use: Bus Access bus Taxi
 Train Own vehicle

Additional comments: _____

PHYSICIAN'S NAME: _____ SIGNATURE: _____

PHYSICIAN'S OFFICE ADDRESS: _____

PHYSICIAN'S OFFICE PHONE #: _____ DATE: _____