VALLEY MEDICAL TRANSPORT

Non Emergency Wheelchair & Gurney Transportation

FAX REQUEST FORM

Phone:(661) 873-1460 **Fax:**(661) 871-1067 **Email:**valley.medical.transport@hotmail.com

PICK-UP INFORMATION

□ **Round Trip** □**One Way** □**Gurney** □**Gerichair** □**Has O_2 tank** □**Aide will ride along** □ **Extra Wide Chair**
(**Please check *ALL* that apply)

Requestor's Name _____ Appt.Date: _____ Appt. Time:_____

Primary Physician: _____ Phone #: _____

Patient's Name: _____

Facility Name: _____

Facility Phone # _____ Facility Fax #_____

Pick up Address: _____ City _____ Zip _____

DROP OFF INFORMATION

Drop off Facility &/or DR. Name: _____

Phone # _____ Fax # _____

Drop-Off Address: _____ City: _____ Zip _____

Purpose of Appointment: _____ Type Of Practice: _____

Diagnosis or ICD-9 Code: _____ *Fax Face Sheet & Physician Order*

(Reason why can't the patient ride in a private car, e.g., wheelchair, amputee, dementia, etc.)

PAYMENT INFORMATION

Please check one of the following:

☐ Medi-Cal #: _____ Issue Date:_____ DOB:_____

If Pt. has other health insurance + MEDI-CAL we need denial letter from other insurance prior to appt. date

☐ Private-pay: Responsible Party_____ ☐ Check ☐ Cash ***DUE AT PICK UP***
Contact Number_____

☐ Credit Card #: _____EXP___/____ Billing Zip Code_____
(additional fees apply; credit card by phone only; NO REFUNDS)

☐ Bill Facility: Authorizing signature_____ Title_____
Print Name_____

OFFICE USE ONLY

Confirmed *Fax* Receipt By : **Name** _____ **Date**____/_____/_____

Confirmed *Appointment* By : **Name** _____ **Date**____/_____/_____

☐ **Special Instructions:**