ShuttleMED **Tel:** 1-888-690-6999/ (714) 939-7849 / **Fax:** (714) 939-7853 (Revised:06/01/14)

TRANSPORTATION APPOINTMENT REQUEST

(When possible, please fax request (1) one week in advance)

Today's Date: _____ / _____ / _____

Appt. Requested By: _____ Contact Tel: ( ) _____-- _____

Patient's name: _____ *(Last Name, First Name)*

Date of Birth: _____ / _____ / _____ ❑ ***Male*** ❑ ***Female***

Medi-Cal or CalOptima #: _____ ❑ ***Eligibility Checked By:*** _____ *(office use)*

Payment Type: ❑ ***CalOptima Auth #:*** _____ *(pls. include a copy)*

❑ ***Insurance with Auth #:*** _____ *(pls. include a copy)*

❑ ***Bill to Facility/SNF:*** **$ _____.00** ❑ ***Cash/Check:*** **$ _____.00**

Patient Status: (Check one) ❑**WHEELCHAIR** *(max: 32" wide)* ❑**GURNEY** ***Weight*:** _____ **lbs.**

Only **ONE companion/caretaker allowed per patient** ***Height*: _____ft._____ in.**

▶ ***(Pick-up location)***

Facility name & address: _____

Street address:_____ Apt # _____

City _____ Zip Code _____

Telephone: ( )_____ **Fax:** ( )_____

Patient's Cellphone: ( )_____ *(if any)*

Appointment Date & Day: _____ / _____ / _____ **(circle one)** *Mon Tue Wed Thu Fri Sat*

Appointment Time: _____ ***am / pm*** to _____ ***am / pm*** *(leave blank if will call)*

Pick-up Time: _____ ***am / pm*** (*at least 45 mins. before appt. time*)

▶ ***(Destination location)***

Facility name & physician: _____

Destination address: Street address:_____ Floor/Suite #: _____

City _____ Zip Code _____

Telephone: ( )_____ **Fax:** ( )_____

Special Instructions: _____

_____

Please *FAX* completed form to (714) 939-7853. We will re-confirm one day prior to Appointment Date.