Standing Order Form

This form must be completed in its ENTIRETY and returned to Southeastrans within 5 business days of the first transport. Please email this form to Southeastrans Inc. at **standingorder@southeastrans.com** or **eFax number: (404) 420-2954**

Submitted By: **Date:**

Name of Healthcare Worker Completing Form (Please Print)		Phone and Fax Number	
Healthcare Worker's email		Healthcare Title	

Attestation of Need for Transportation

I do hereby certify that I have **no other means of transportation** available within my household to attend the facility/ program identified on this form. I understand that falsification or misrepresentation of any information may result in denial of Medicaid Non-Emergency Transportation Services or termination of current transportation services.

Medicaid Member or Legal Representative Signature (required): X_____

Member's Information

Member's Name				Telephone Number	
Street Address				Apartment Number/ Apartment Name	
City		GA		Zip Code	
Medicaid Number		Date of Birth	/ /	☐ Female ☐ Male	
Emergency Contact Name		Emergency Contact Phone Number			

☐ New ☐ Renewal ☐ Change ☐ Public Transportation Driver Name: _____

Transport Information

Pick-up From		Address		*(Include Apt/Room No.)*			
City		GA	Zip		Telephone Number		
Transport To (Facility Name)		Address					
City		GA	Zip		Telephone Number		
☐ One Way Transport		☐ Round Trip Transport					

Medicaid Waiver Information

Medicaid Waiver Program ☐ No ☐ Yes If Yes, ☐ CCSP ☐ SOURCE ☐ COMP ☐ ICWP ☐ NOW

Case Manager Name CM Phone#:

Treatment Information

Purpose of Appointment and CPT Codes **(Required - Please be specific)**					
First Date of Service		Duration of Treatment	**(Write Number)**	☐ Weeks ☐ Months	
Appointment Time		AM PM	Return Pickup Time		AM PM
Appt Days	Mon Tue Wed Thu Fri Sat			(Circle All That Apply)	

Mobility

☐ Ambulatory ☐ W/C ☐ Electric W/C ☐ Oversize W/C ☐ Stretcher (_____' ____") (_____lbs)
Height **Weight**

☐ Escort Required

Can this Member use public transportation?	☐ No ☐ Yes	If no, why?

Under contract with the Georgia Department of Community Health, Southeastrans, Inc. is the Georgia Medicaid Non-Emergency Transportation Broker for the member referenced. The purpose of this form is to gather information to ensure that the requested services being provided to the Medicaid Members of Georgia are within the guidelines established by both Federal and State Medicaid Agencies. **STATEMENTS ON THIS DOCUMENT ARE MADE UNDER THE PENALTY OF STATE AND FEDERAL MEDICAID FRAUD GUIDELINES.**

Southeastrans reserves the right to verify the information provided on this form by site visits, patient and employee interviews, and other methods. Any discrepancies found will be reported to the appropriate State and Federal Medicaid Fraud Control Units. This together with any attachments is intended only for the use of the individual or entity to which it is addressed. It may contain information that is confidential and prohibited from disclosure. If you are not the intended recipient, you are hereby notified that any dissemination or copying of this form or any attachment is strictly prohibited. If you have received this message in error, please notify the original sender immediately by telephone or by returning this form.