SOUTHEASTRANS
DRIVING THE FUTURE OF TRANSPORTATION MANAGEMENT

Urgent Care Request Form

Date Received:

Date		CSR/SSR	**(E-FAX:** 404 420-2954 or standingorder@southeastrans.com **)**	Time	

Requested By		Title	

Member Information

Last Name		**First Name**		**Middle Initial**	
Street Address (Include NE,SE, etc.)				**Apt or Room No**	
City		**GA**	**Zip**	**Age**	
Apartment Complex Name		**Telephone Number**		**ID Number**	

MEDICAID #: _____

Urgent Care Requests

URGENT CARE REQUESTS ARE FOR AN UNSCHEDULED EPISODIC SITUATION, IN WHICH THERE IS NO IMMEDIATE THREAT TO LIFE OR LIMB, BUT THE MEMBER MUST BE SEEN ON THE DAY OF THE REQUEST AND TREATMENT CANNOT BE DELAYED UNIT THE NEXT DAY. THIS REQUIREMENT SHALL ALSO APPLY TO APPOINTMENTS ESTABLISHED BY MEDICAL CARE PROVIDERS ALLOWING INSUFFICIENT TIME FOR ROUTINE THREE (3) DAY SCHEDULING. URGENT CARE IS AS FOLLOWS:

1. Chemotherapy 2. Radiation 3. Dialysis 4. Hospital discharges
5. Post-surgical and/or medical follow-up care specified by a health care provider to occur in fewer than three days.
6. Result of administrative, representative or technical delay caused by Southeastrans, Inc. requiring that an appointment be scheduled.
7. Imminent availability of an appointment with a specialist when the next available appointment would have a delay of two or more weeks.

TRIP INFORMATION

Appointment Date(s)			**Appointment Time(s)**		
Facility Name		**Street Address (Include Suite Number)**			
City			**GA**	**Zip Code**	
Contact Person			**Telephone Number**		
Escort Required	☐ Yes ☐ No	**If yes, Escort's Name**		**Reason for Escort**	
Mobility	**Ambulatory** ☐	**Wheelchair** ☐	**Stretcher** ☐		

Additional Information: _____

Authorized Personnel's Printed Name _____ **Title** _____

Authorized Personnel's Signature _____