

Indiana Standing Order Request Form

This form must be completed in full and returned to Southeastrans within 5 business days of the first transport. **Please fax to 317-642-0913.** Please remember that you are responsible for informing Southeastrans of changes (Address, Phone Number, Time and Days) or cancellation of treatment. You will also be asked to recertify orders every six (6) months for Dialysis standing orders and every three (3) months for all others to avoid cancellation of the standing order. If you have any questions, please call the **Southeastrans Facility Line at 1-855-325-7588.**

Member Name _____	Medicaid Number _____
Member's Complete Address: _____	
Member's Phone () _____	Alt Phone () _____
Emergency Contact _____	Phone () _____
DOB ____/____/____	Gender M or F CPT Code _____ Treatment _____
Please check one NEW <input type="checkbox"/> CHANGE <input type="checkbox"/> RECERTIFY <input type="checkbox"/>	

FACILITY NAME: _____	Phone #: _____
START DATE ____/____/____	Days of the Week: S M T W TH F S (circle all that apply)
Special Instructions: _____	
START TIME _____ am/pm	END TIME _____ am/pm
Member's Mobility (circle one): Ambi W/Chair Electric W/C BLS* ALS* Bariatric (requires add'l attendant)	
* BLS and ALS will require a completed Letter of Medical Necessity (LMN).	

Pick-Up Address: _____	Phone #: _____
Drop Off Address: _____	Phone #: _____
Circle One: Round Trip One Way	
Alternate Return Address: _____	
Is Member able to use Public Transit? (Circle one) Yes or No	
If no, member will be required to have a Public Transit Restriction Form on file.	
Current Transportation Provider (if known) _____	

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.

Requestor Name: _____ **Phone:** () _____