Southeastrans Nursing Home Transportation Request Form

Direct any questions to Southeastrans Toll Free at **(855) 325-7588** or fax completed form to **(317) 317-0819**. **THIS CANNOT BE USED FOR STANDING ORDERS - MUST SUBMIT A STANDING ORDER FORM.**

NOTE: Routine appointments be submitted within a minimum 2 business days of the appointment date. Urgent requests may be submitted with less than 2 days' notice but **may** be verified for medical necessity before they are completed. Please **do not** send requests for appointments more than 30 days out

Nursing Home Name:			Contact Person (nurse Or Social Worker):	
Nursing Home Address:			Phone Number:	Fax number:
City:	County:		State:	Zip Code:
Appointment Date:			Appt Time: ☐AM ☐PM	Return Time: ☐AM ☐PM
Day of the Week the Appointment is on (Circle one): ☐Mon ☐Tue ☐Wed ☐Thu ☐Fri ☐ Sat ☐Sun				
Member/ Patient's Name:			Medicaid Number (12digits)	
Member/ Patient's Date of Birth:			Appointment type:	
Destination Facility's name:			Member/ Patient's Gender: ☐Male ☐Female	
Destination Facility's Street Address:			Doctor's Name/ Department/ Floor/ Suit number (Important):	
City:	County:		Destination Phone Number (Required):	
State:	Zip Code:	Floor/Wing:	Room Number	Bed Number:
Mode of Transportation: ☐AMB ☐Manual WC ☐Electric WC ☐Basic Life Support (BLS) ☐Advance Life Support (ALS) (BLS and ALS Require LMN)				
Escort Required? ☐Yes ☐No Traveling Information: ☐Riding with Mbr ☐Meeting at facility			For Wheelchair: WC Width- Weight-	For ALS/BLS: Height- Weight-
Escort name: Escort phone number: Preferred transportation provider:			Escort Relationship to patient: ☐Nursing Home Staff ☐Family ☐Other_____	Does patient need an attendant? (Attendant will only assist the Patient while in the vehicle) ☐Yes ☐No
Has the Patient had contact with anyone confirmed with COVID 19 in the past 14 days or have they experienced symptoms of COVID-19 such as a high fever or persistent cough? ☐Yes ☐No			Is the Patient willing to wear a Mask and use hand sanitizer? ☐Yes ☐No*** *** The transportation provider may provide the Member with them during their trip and request that they wear them. Failure to use these items may result in the provider declining to transport the Member.	

Please contact your Special Service Representative if you have not received a confirmation number within 24 hours of appointment. Make copies of this form. Whenever you need to make an appointment, it is Important that you fully complete this form or may not be able to schedule the appointment.

The purpose of this form is to gather information to ensure the services being provided to the Medicaid Members of Indiana are within the guidelines established by both Federal and State Medicaid Agencies. STATEMENTS ON THIS DOCUMENT ARE UNDER THE PENALTY OF STATE 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

Trip ID Number (Internal Use Only) _____