

Middle Region TN

Standing Order Form

This form **MUST** be completed **IN FULL** and returned to Southeastrans within 5 business days of the first transport. Please **FAX** this form to your Southeastrans Inc. Standing Order Representative_ to (423) 370-1422. By completing this transportation request, I do hereby declare, under penalty of State and Federal Medicaid guidelines, that the information indicated on this form is true and accurate.

Submitter's Information

Date of Submission:

Name of Healthcare Worker Completing Form (Please Print)	Phone <u>and</u> Fax Number
Healthcare Worker's email	Healthcare Title
Healthcare Workers Signature (required):	

Member's Information

Member's Name	Telephone Number
Street Address	Apartment Number/ Apartment Name
City	TN Zip Code
"M" Number	Soc. Sec. Number - - <input type="checkbox"/> Female <input type="checkbox"/> Male
Date of Birth / /	Emergency Contact Name & Phone Number
<input type="checkbox"/> New <input type="checkbox"/> Renewal <input type="checkbox"/> Change	

Transport Information

Pick-up From (Residence)	Address	(Include Apt/Room No.)
City	TN Zip	Telephone Number
Transport To (Facility Name)	Address	
City	TN Zip	Telephone Number
<input type="checkbox"/> One Way Transport		<input type="checkbox"/> Round Trip Transport

Treatment Information

Purpose of Appointment and CPT Codes (Required - Please be specific)			
First Date of Service	Duration of Treatment	(Write Number)	<input type="checkbox"/> Weeks <input type="checkbox"/> Months
Appointment Time	AM PM	Return Pickup Time	AM PM
Appt Days	Mon Tue Wed Thu Fri Sat	(Circle All That Apply)	

Mobility Information

<input type="checkbox"/> Ambulatory	<input type="checkbox"/> W/C	<input type="checkbox"/> Electric W/C	<input type="checkbox"/> Oversize W/C	<input type="checkbox"/> Stretcher	<input type="checkbox"/> Escort Required
Can this Member use public transportation?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If no, why?			

The purpose of this form is to gather information to insure that the requested services being provided to BlueCare members 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.