LogistiCare Solutions
3280 N. Cimarron Rd
Las Vegas, NV 89129

OR TRANSPORTATION REQUEST FORM

(For one time trip)
We recommend this form be submitted within 48 hours prior to the appointment date Please complete all fields on the form or trip will not be scheduled
FAX # 8558825627 PHONE # 8442876698

Facility Name:	Trip Requestor:	Date of Trip:
Member's Name (Last, First, MI)		Insurance Type:
Member ID #		Special needs:
DOB: ____/____/____	Escort: ❑ Yes ❑ No	
Phone #	Fax #	

LEVEL OF SERVICE:

❑ Ambulatory ❑Wheelchair ❑ Stretcher ❑Mass Transit ❑Mileage Reimbursement ❑ Secure Transport

Wheelchair: Please provide the following information

Type of Wheelchair: ❑ MANUAL ❑ ELECTRIC ❑ SCOOTER ❑ N/A

Weight: Height: Stairs:(how many steps): Ramp: ❑ Yes ❑ No

Is the member able to transfer to a sedan vehicle: ❑ Yes ❑ No

PICK-UP INFO

Facility Name/Residence:	Phone #
Address:	City, State ZIP

DROP-OFF INFO

D/O Facility/Complex Name:	Phone #
Address/Suite:	City, State, ZIP
Appointment Time ❑ AM ❑ PM	Return Time: ❑ AM ❑ PM **OR**
❑ One Way or ❑ Round Trip	Will Call ❑ Yes ❑ No

In order to be processed ALL fields MUST be completed and legible. Failure do so could result in trip Not being processed
(We recommend this form be submitted 48 hours prior to the appointment day)

NAME (Please Print): _____ SIGNATURE: _____ DATE: