



**LogistiCare Solutions**  
**3280 N Cimarron Dr.**  
**Suite 107**  
**Las Vegas, NV 89129**

**OR STANDING ORDER FORM**

**FAX # (855) 882-5627**

**PHONE # 1-844-287-6698**

Member's Name:		Insurance Type:	
Member's Insurance ID#		Gender: Female / Male	DOB: / /

**APPOINTMENT INFORMATION**

<b>Appointment Days</b> <input type="radio"/> Monday <input type="radio"/> Tuesday <input type="radio"/> Wednesday <input type="radio"/> Thursday <input type="radio"/> Friday <input type="radio"/> Saturday <input type="radio"/> Sunday	Appt. Time: <input type="text"/> AM <input type="text"/> PM	<b>Level of Service:</b>	
	Return Time: <input type="text"/> AM <input type="text"/> PM	<input type="radio"/> Ambulatory	<input type="radio"/> Wheelchair
		<input type="radio"/> Mass Transit	<input type="radio"/> Stretcher
		<input type="radio"/> Mileage Reimbursement	<input type="radio"/> Secure Transport
		If Stretcher provide precautions: _	
	Start Date: _/ _/	Height: _____	Weight: _____
	End date: _/ _/	Ongoing <input type="radio"/>	
Special Needs:	Can the member sign the driver's log? <input type="radio"/> Yes <input type="radio"/> No		
	Will signature status be permanent? <input type="radio"/> Yes <input type="radio"/> No		
	<b>Physician's Signature:</b> _____		

**PICK-UP INFORMATION**

Facility/Complex Name:	Phone #
Address:	City, State, Zip

**DROP-OFF INFORMATION**

Facility/Complex Name:	Phone #
Address:	City, State, Zip

<b>Treatment Type:</b> <input type="radio"/> Dialysis <input type="radio"/> Substance Abuse <input type="radio"/> Mental Health <input type="radio"/> Adult Day Care <input type="radio"/> Other _____	<b>Ordering Party:</b> Name: _____ Title: _____ Phone#: ( ) _____ Fax#: ( ) _____
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**NAME:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

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