



## Verida Nursing Home Transportation Request Form

Direct any questions to Verida 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: <input type="checkbox"/> AM <input type="checkbox"/> PM		Return Time: <input type="checkbox"/> AM <input type="checkbox"/> PM
Day of the Week the Appointment is on (Circle one): <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun					
Member/ Patient's Name:			Medicaid Number (12digits)		
Member/ Patient's Date of Birth:			Appointment type:		
Destination Facility's name:			Member/ Patient's Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> AMB <input type="checkbox"/> Manual WC <input type="checkbox"/> Electric WC <input type="checkbox"/> Basic Life Support (BLS) <input type="checkbox"/> Advance Life Support (ALS) (BLS and ALS Require LMN)					
Escort Required? <input type="checkbox"/> Yes <input type="checkbox"/> No Traveling Information: <input type="checkbox"/> Riding with Mbr <input type="checkbox"/> Meeting at facility			For Wheelchair: WC Width- Weight-		For ALS/BLS: Height- Weight-
Escort name:			Escort Relationship to patient: <input type="checkbox"/> Nursing Home Staff <input type="checkbox"/> Family <input type="checkbox"/> Other _____		Does patient need an attendant? (Attendant will only assist the Patient while in the vehicle) <input type="checkbox"/> Yes <input type="checkbox"/> No
Escort phone number:					
Preferred transportation provider:					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is the Patient willing to wear a Mask and use hand sanitizer? <input type="checkbox"/> Yes <input type="checkbox"/> 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. Verida 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