West Virginia Operations
Facility Department
602 Virginia St. E
Charleston, WV 25301
Fax: (855) 882-5998

TRANSPORTATION REQUEST FORM

(For single date trip requests)
Must be submitted 5 business days prior to the appointment day.
Trip requests with less than a 5-business day notice must be called in.
To be processed ALL fields MUST be completed and legible; failure to do so will result in the trip request being denied.

Facility:	Trip Requestor:	Professional Title:
Requestor Phone:	Requestor Fax:	Trip Date:

Member Name (Last, First, MI):		Special Needs: (Please include special equipment or pick-up/drop-off instructions)
DOB: _____/_____/_____	Escort: ☐ Yes ☐ No	
Insurance Type:	Medicaid ID #:	☐ Car Seat (*Member must provide car seat)*

LEVEL OF SERVICE AND LEVEL OF ASSISTANCE:

☐ Curb-To-Curb ☐ Door-To-Door ☐ Hand-To-Hand

☐ Ambulatory ☐ Wheelchair ☐ Mileage Reimbursement ☐ Public Transit

Medical Condition that Requires Wheelchair:_____

Weight:_____ Height:_____ Stairs(#):_____ Wheelchair Type: ☐ Manual ☐ Power

(Height and weight are required for all wheelchair requests)

Member is able to transfer from his or her wheelchair, in and out of a vehicle safely: ☐ Yes ☐ No

PICK-UP INFORMATION

P/U Facility Name/Residence:	Phone:
Address/Apt:	City, State ZIP:

DROP-OFF INFORMATION

D/O Facility/Complex Name:	Phone:
Address/Suite:	City, State Zip:
Appointment Time: _____ ☐ AM ☐ PM ☐ One Way or ☐ Round Trip	Will Call: ☐ Yes ☐ No Return Time: _____ ☐ AM ☐ PM
Appointment Reason:	Does your facility provide its own transportation? ☐ Yes ☐ No Requested Provider Name: ("not guaranteed")

NAME: _____ **SIGNATURE:** _____ **DATE:** _____