



West Virginia Operations  
 Facility Department  
 602 Virginia St. E  
 Charleston, WV 25301

## STANDING ORDER FORM

(Please fax to the number provided at least 5-days before the initial trip)

Fax: 855-882-5998 | Phone: 844-889-1941

Member's Name:	Insurance Type:	<input type="checkbox"/> New <input type="checkbox"/> Update Existing
Member's Medicaid ID #:	Gender: Female / Male	DOB: ___/___/___

### APPOINTMENT INFORMATION

<b>Appointment Days</b>  <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	Appt. Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	Level of Service: (Please select the appropriate Level of Service) <input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheelchair* <input type="checkbox"/> Mileage Reimbursement <input type="checkbox"/> Public Transit *Member's condition that requires wheelchair:
	Return Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
	Start Date: ___/___/___	Height: _____ Weight: _____ (Height and weight are needed for all wheelchair requests)
	End Date: ___/___/___	Assistance Level: <input type="checkbox"/> Hand-to-Hand <input type="checkbox"/> Door-to-Door <input type="checkbox"/> Curb-to-Curb
	Special Needs:	Can the Member sign the driver's log? <input type="checkbox"/> Yes <input type="checkbox"/> No Will signature status be permanent? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Requested Provider's Name (not guaranteed):</b>

### PICK-UP INFORMATION

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

### DROP-OFF INFORMATION

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

<b>Treatment Type:</b> <input type="checkbox"/> Adult Daycare <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Therapeutic Day TX <input type="checkbox"/> Day Support <input type="checkbox"/> Supported Employment <input type="checkbox"/> Dialysis	<b>Requesting Party:</b> Name: _____ Title: _____ Phone: ( ) _____ Fax: ( ) _____
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NAME: \_\_\_\_\_

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

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

Caution: This information contains confidential and proprietary trade secrets, the release of which could cause competitive harm. It is not subject to disclosure under any freedom of information act or open records act law or regulation. Do not further disclose.