MAS Backdated Trip Request Form

Email completed form to: TripInvResolution@medanswering.com

DATE SUBMITTED TO MAS: ____/____ / _____

Request From: _____ **at** _____

Phone #: (_____) _____ - _____ **Fax #:** (_____) _____ - _____

How do you wish to be notified? ☐ **Phone** ☐ **Email**

Enrollee Name: _____ **DOB:** ____ / ____ / _____

Medicaid #: _____ *(XX00000X format)* ☐ **Pending Medicaid** ☐ **County 97/98**

Date of Service: ____ / ____ / _____ **Appt Time:** _____ **Appt Type**: _____

Pickup Address: _____

Drop off Address: _____

Round Trip: ☐ Yes or ☐ No **Standing Order**: ☐ Yes or ☐ No If "Yes" days of week:

☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa ☐ Su *and* **End Date:** _____

Mode: ☐ Taxi ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance: BLS *or* ALS _____

Multiple Appointments to the Same Location? ☐ Yes or ☐ No

If "Yes", Dates: _____

Enrollees' Medical Provider: _____ **Medical Provider NPI#:** _____

Transportation Provider: _____ **Provider ID #:** _____

Special Instructions:

_____

_____

_____