MAS Backdated Trip Request Form

Email completed form to: backdatedtrips@medanswering.com

DATE SUBMITTED TO MAS: ____ / ____ / _____

Request From: _____ **at** _____

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

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:

_____

_____

- **You will receive an email when your request is completed.**
- **Please note, it is your responsibility to actively check your roster.**
- **If your backdated trip is approved, you will have 30 days from the date it was entered to attest to the trip.**