REQUEST FOR AUTHORIZATION

(Authorization numbers will be given within (24) hours of request)

Facility/Transportation Provider: ________________________________

Contact Name: ____________________ **Date:** ____________________

Phone Number: ____________________ **Fax Number:** ____________________

Is the recipient's stay at the facility being reimbursed by Medicare? (Check one) ☐ YES ☐ NO

Does the visiting doctor participate in the Maryland Medicaid Program? (Check one) ☐ YES ☐ NO

GENERAL PATIENT INFORMATION

11-DIGIT MEDICAID ASSISTANCE NUMBER (MA#) (REQUIRED): ____________________

Last Name: ____________________ **First Name:** ____________________

Address (Including Zip Code): ________________________________

Phone Number: ____________________ **DOB:** ____________________

Is client Ambulatory? (Check one) ☐ YES ☐ NO **Does Facility provide any form of transportation? (Check one)** ☐ YES ☐ NO

If "YES", please describe transportation: ________________________________

ORIGIN

Home/Facility Name: ____________________ **Phone Number:** ____________________

Address (Including Zip Code): ________________________________

Purpose of trip: ________________________________

If trip is NOT for a doctor's appointment, explain: ________________________________

Date(s) of service: ________________________________

Mode of transportation required: (Check one) ☐ Ambulance ☐ Stretcher ☐ Wheelchair Van ☐ Geri Chair

DESTINATION

Physician/Facility Name: ________________________________

Address (Including Zip Code): ________________________________

Phone Number: ____________________ **Specialty:** ____________________

MONTGOMERY COUNTY DEPARTMENT OF TRANSPORTATION
DIVISION OF TRANSIT SERVICES
ENHANCED MOBILITY AND SENIOR SERVICES SECTION
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