

Request for Transportation provided by **On Time MedTrans** 800-372-3372

Fax 800-376-0448 Request From: (print facility name)

Contact Name: _____

Phone: _____ Ext#: _____ Fax: _____

Patient Information (Please print clearly)

Date of Order _____ / _____ / _____ Date of Service _____ / _____ / _____

Pick-up Time _____: _____ Appointment Time: _____: _____ Back Time: _____: _____

Will call: _____ Round Trip: _____ One-way: _____ # Steps _____ # of companions: _____

Stretcher: _____ Wheelchair own: _____ ours: regular _____ elevating _____ wide _____ ex-wide _____

M _____ F _____ DOB: _____ / _____ / _____ approximate weight: _____

Phone _____ Patient's Name: Last _____

From: _____

Destination: _____

Phone: _____ Doctor/Medical: _____

**Must be completed by authorized person only _____ Direct billing
(Required signature to guarantee payment must be completed below)**

Name: _____

Title _____

Billing address: _____

Phone: (_____) _____ ext _____ Fax _____

Claim /Case Number: _____

I hereby authorized the above transportation.

Signature: _____ Date: _____