267 S Joe Martinez Blvd. Pueblo West Co. 81007

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Level Of Service Medical Recommendation Form

Dear Medical Professional:

MedRide has received a request for transportation for one of your patients. Please complete this Level Of Service Form in its entirety and fax back to us.

First Name:_____ Last Name: _____ Date Of Birth: _____

Medicaid # _____ Phone #: _____

Address: _____
City: _____ State: _____ Zip: _____

Diagnosis that supports transportation limitations (MUST PROVIDE)

_____

Home Life

_____ Lives Alone(or with family) _____ Nursing Facility _____ Group Home
_____ Residential Rehab Facility

Comments:_____

Does patient use any of the following assistive devices?

_____ Cane _____Crutches _____Walker _____ Portable Oxygen _____ Service Animal
_____Electric Wheelchair _____ Manual Wheelchair

Can Patient self-propel in wheelchair? _____Yes _____ No
Can Patient self-transfer from wheelchair? _____ Yes _____ No

If the following contains to the patient, please mark the correct line.

Cataracts _____ Legally Blind _____ Deaf _____

Medical Professional Printed Name :_____ **Phone #**:_____

Medical Professional Signature:_____ **NPI #** _____

*By signing, the medical professional certifies and attests that each statement is accurate and true to the best of their knowledge.