MEDRIDE

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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.

Patient Information

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

Medicaid # _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Diagnosis that supports transportation limitations (MUST PROVIDE)

_____

Escort

Does this patient require an escort for assistance during transportation because of:

Age - Minor Under 17 _____

Mental Wellness _____

Physical Aid _____

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

Facility Information

Facility Name:_____

County Facility Is In:_____

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.

**** Medride LLC shall not be responsible for the loss, damage or destruction of Employee's or Client's personal property while such property is within the Company's vehicles.**