hopelink

HCA Medicaid Transportation Broker
A HIPAA Business Associate of HCA

King County 800.923.7433 FAX 425.644.9447
Snohomish County 855.766.7433 FAX 425.644.9447

Repeat Start Date: _____

Today's Date: _____

~ Repeat Appointment Request ~

FAX MUST BE RECEIVED 2 BUSINESS DAYS IN ADVANCE BEFORE 5:00 PM

Client Name: _____ ProviderOne ID #: _____
(Last Name, First Name, M.I.) *(NOT case number) (May substitute D.O.B.)*

Description of Request / Comments: _____
(New Repeat Appointment, Changing Existing Schedule, etc.)

This information supplied by: _____ Phone #: _____

Is the client able to travel to and from their appointment(s) independently? YES NO

DRIVERS DO NOT PROVIDE ASSISTANCE BEYOND THE MAIN DOOR OF THE APPOINTMENT
NOR DO THEY SERVE AS ATTENDANTS, IF YOU ANSWERED NO TO THE ABOVE QUESTION THE CLIENT OR CAREGIVER MUST ARRANGE TO HAVE AN ATTENDANT PROVIDED

Is the client a wheelchair / Scooter user? YES NO If yes, what size? Standard Extra Large
(Standard sized wheelchair is 48" x 30" measured wheel to wheel.)

Total Number of Riders: _____ *(More than 3 riders may limit the transportation resources available and result in service delays.)*
If additional riders are Medicaid eligible and going to a covered service, please submit a separate request form.

Other Client mobility aids / Special needs: _____
(Example: Can transfer unassisted from WC into sedan vehicle, is visually impaired, etc.)

Can the client use Metro's Fixed Route Service to access this appointment? YES NO
(If no, an approved Higher Mode Exception, or Verification of ADA Eligibility must be on file)

REPEAT SCHEDULE *Appointment Time / Return Time (please use military time if possible)*

SUN: _____ /_____ MON:_____ /_____ TUE:_____ /_____ WED:_____ /_____ .

THR:_____ /_____ FRI:_____ / _____ SAT:_____ /_____ .

Pickup Address: _____ (Must have street address) Apt/Ste #: _____

City: _____ Zip: _____ Phone #: _____ Entrance: _____

Drop off Address: _____ (Must have street address) Apt/Ste #: _____

City: _____ Zip: _____ Phone #: _____ Entrance: _____

Facility: _____ Seen by: _____

Medical Reason for Appointment: _____
*(*This is the minimal information needed to document that the service is covered and that there are no closer medical providers —*"Check-up," "Eval," or "Follow-up" are too vague)*

Will the service that the client receives be billed to medical coupons (Title 19)? YES NO

Confirmation Phone: _____ Fax #: _____
(IN ORDER TO RECEIVE A CONFIRMATION YOUR FAX MUST BE ON 24 HOURS A DAY)

Request Completed? YES NO Hopelink Staff: _____ Date: _____

Comments: _____

Scheduled Pickup Time: _____ Scheduled Return Time: _____