Transportation Request Form
RMT
Rochester Medical Transportation
150 Josons Drive Rochester, New York 14623 Tel: (585) 288-3444 Fax: (585) 654-9543

Facility Request From:

Contact Phone: EXT FAX:

Patient Information (Please Print Clearly)

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

Pick up Time: ____:____ Appointment Time: ____:____ Return Time:___:____ or Will Call: ___

Round Trip: ____ One-Way: ____ #Steps: ____

Stretcher: ___ **Wheelchair**: Facility:___ RMT: ___ Regular ___ Ex-Wide ____ **Ambulatory** ____

From: _____

Destination: _____

Patient Last Name _____ First Name _____

M __ F__ DOB: ____/____/____ Weight: _____ # of Companions: _____

Method of Payment-Select one and complete all information

____Medicaid County: _____ ID # _____

For RMT Use Only: *Prior Approval #* _____

Medical Reason for Stretcher or Wheelchair transport:

For Credit Cards or COD payments attach authorization form and mark the trip in the system

OTHER INSURANCE

MVA * _____ Workman's Comp** _____

Policy # _____ Date of Accident or Injury _____

Insurance Company _____ Adjuster _____ Phone

Address _____

* Assignment of Benefit Form Required for MVA insurance

**Employer _____

Private Pay Billing Information

Responsible Party:

Name: _____ Phone: (____) _____-_____

Address: City: State: ZIP:

Payment agreement for direct billing only

I hereby accept the above transportation and will take full responsibility upon myself for the payment

Social Security # - - Signature