VERIDA

Date Complete _____
SSR_____
Provider Assigned_____
Eligibility Verified_____

Indiana Standing Order Request Form

This Form Must be completed in FULL and returned within 5 business days of the first transport. Please Fax to **317-613-0819**. Please remember that as the requester you are responsible for informing Verida of changes (address, phone number, time, or days) or cancelation of treatment. You will also be asked to recertify orders every six (6) months for Dialysis standing orders or every three (3) months for all other standing orders to avoid cancellation of the standing order. Please remember that the Member must have two (2) or more reoccurring appointments each week for a minimum or 6 weeks to qualify for a Standing Order. If you have any questions, please call the **Verida Facility Line at 1-855-325-7588**.

Member Name _____ Medicaid Number _____

Member's Complete Address _____

Member's Phone # (_____) _____ Alt Phone # (_____) _____

Emergency Contact _____ Relation _____ Phone # (_____) _____

D.O.B. __/__/_____ Gender M or F CPT Code_____ Treatment _____

Please Check One (1) NEW ☐ CHANGE ☐ RECERTIFY ☐

FACILITY NAME _____ Phone # (_____) _____

Start date __/__/_____ Days of the Week: Su M T W Th F Sa (Circle all that apply)

Special Instructions _____

Start Time _____ AM/PM End Time _____ AM/PM

Member's Mobility: AMB W/C Electric W/C BLS* ALS* Bariatric BLS* Bariatric ALS*
(Requires and additional attendant)

*Requires a Letter of Medical Necessity (LMN)

Height __FT___IN
Weight _____LBS
Chair Width ___IN
Steps at home?
N or QTY_____

Pick-up address _____ Phone # (_____) _____

Facility Address _____ Phone # (_____) _____

Circle one (1): Round Trip One Way

Additional appointment address _____ Phone # (_____) _____

Is the Member able to use Public Transit? (Circle one (1)) Yes or No**

**Member will need a Public Transit Restriction Form (PTRF) on File

Current Transportation Provider (If Known) _____

Has the Member had contact with anyone confirmed with COVID 19 in the past 14 days or have they experienced symptoms of COVID-19 such as a high fever or persistent cough? **YES or NO**	Is the Member willing to wear a Mask and use hand sanitizer? **YES or NO*** *** The transportation provider may provide the Member with them during their trip and request that they wear them. Failure to use these items may result in the provider declining to transport the Member.

STATEMENTS ON THIS DOCUMENT ARE MADE UNDER THE PENALTY OF STATE AND FEDERAL MEDICAID FRAUD GUIDELINES. Verida reserves the right to verify the information provided on this form by site visits, patient and employee interviews, or other methods deemed necessary. Any discrepancies found will be reported to the appropriate State and Federal Medicaid Fraud Control Units. This, together with any attachments, is intended only for the use of the individual or entity to which it is addressed. It may contain Information that is confidential and prohibited from disclosure. If you are not the intended recipient, you are hereby notified that any discrimination or copying of this form, or any attachment, is strictly prohibited. If you received this message in error, please notify the original sender immediately by telephone or by returning this form.

By signing below I acknowledge that I have read the above statement, have ensured that all the information provided on this form is filled out fully and accurately, to the best of my knowledge, and am giving permission to Verida to use the included information for the purposes of creating a Standing Order and maintaining transportation.

Facility Requestor Name (Print) _____ Phone # (_____) _____

Facility Requestor Signature _____