



Trip Information

Name

Phone

Fax

Email:

Home Pickup Address

Street Address

City

Zip Code

Date of Birth

Health First Colorado ID #

Destination Address

Name of Doctors's Office,

Facility, Etc.

Street Address

City

Zip Code

Physician Name

One Way/Return Trip?

One Way

Transportation Home Needed

Date of Appointment

Time of Appointment

Transportation Home Time (If selected above)

Mode of Transportation

Private Vehicle

Bus Pass

Mileage Reimbursement

Other

PLEASE NOTE! If you have not submitted a MCTS form you will only qualify for the next available mode of transportation depending on location.

Will you have a personal attendant?

Yes

No

Trip Reason (be specific)

Agreement & Signature

I understand if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both. I certify, under penalty of perjury, that the information provided is accurate to the best of my knowledge. I understand for ambulance transports, a Certificate of Transportation Services (CTS) (available on www.medicaidco.com) or an equivalent doctor's statement is required. If Veyo, LLC does not receive required documentation within 2 business days of the initial request date, the request will be denied. DENIED REQUESTS CAN ALWAYS BE RESUBMITTED WITH THE REQUIRED DOCUMENTATION.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If you would like to print and fax please do so to Fax#: 888-316-2723