



FIRST CHOICE AMBULETTE TRANSPORTATION
REQUEST FOR SCHEDULED APPOINTMENTS

Name of Patient _____ Room # _____

Pick-up location: _____

Destination _____

Appt. Date _____ Appt. Time _____ One Way _____ Round Trip _____

Medical reason for appt. (BE SPECIFIC) _____

NAME & ADDRESS OF RESP. PARTY LISTED BELOW, IF OTHER THAN RESIDENT:

Name: _____

Address: _____

Has responsible party been informed of appointment? Yes _____ No _____

Has responsible party been informed that he/she will be responsible for transportation costs for this trip? Yes _____ No _____

Do you require an escort to accompany the patient? Yes _____ No _____

D.O.B. _____

Person placing request _____

Physician _____

Date _____

Completed by: _____

Special Needs: _____

Spoke to: _____

O2 _____

Pick-up time: _____

Resp. Precautions _____

Date placed: _____

Wheelchair _____

Medicare #: _____

Medicaid #: _____

**Private Pay: _____ Method of Payment: *MasterCard / Visa [] Check [] Cash []

*Credit Card Type: Visa [] MC [] Credit Card No.: _____

Exp. Date: _____ SIC # (3 digit code on back of card) _____

**Accepted methods of payment: VISA, MasterCard, Cash, Check. First Choice will mail invoices if payment is not made via credit card. Invoices will be sent after service has been completed.

Submit a copy of the completed form via fax to:

First Choice - Attn: Regina Willis
Contact Ph. #: (216) 509-6638 • Fax: (216) 521-2220