Single Trip Form

All blanks must be accurately completed and legible. Incomplete forms may be returned

CountyCare HEALTH PLAN
799 Roosevelt Road, Bldg 4, Suite 200
Glen Ellyn, IL 60137
Phone: (630) 403-3210
Fax: (630) 873-1440

Member Name: _____

Member ID/ RIN: ___ ___ ___ ___ ___ ___ ___ ___ ___ Date of Birth: _____

Requestor's Name _____ Today's Date _____

Requestor's Relationship/Title _____ Call Back Phone No. _____

Requesting Organization _____ Fax Number _____

Trip Information

Trip Date _____ Appt Time _____ Pick-up Time _____

Reason for Trip: _____

☐ Round-Trip
☐ One-Way
☐ Other _____

Origin

Identifier/Name _____

Phone No. _____

Address _____

City _____ State _____

Zip Code _____ County _____

Referring Dr's Name _____

Referring Dr's Phone No. _____

Destination

Identifier/Name _____

Phone No. _____

Address _____

City _____ State _____

Zip Code _____ County _____

Medical Provider Name: _____

Most Direct Phone No. to Validate _____

Category of Service Options (Select the most economical category of service that will meet the member's needs)

☐ Private Auto (055)

☐ Fixed Route (Bus/Train)

☐ Service Car (054) OR Taxi (053)
___ Non-Employee Attendant
___ Employee Attendant

☐ Medicar (052)
___ Wheelchair ___ Stretcher
___ Non-Employee Attendant
___ Employee Attendant

☐ Non-Emergency Ambulance (051)
___ BLS
___ ALS
___ Oxygen/Supplies

Agreement and Signature

I understand that 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 on this form is accurate to the best of my knowledge. I understand for prior approval ambulance transports, a Certificate of Transportation Services (CTS) or an equivalent doctor's statement is required. If First Transit does not receive required documentation prior to the transport, the request will be denied.

_____ _____

Requesting Person's Signature Date Signed