



Ancillary Services Form

Please Print

Participant Information

Name: _____
 Parent/Guardian Name: _____
 MO HealthNet Number: _____ Date of Birth: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone #: _____ Alternate #: _____

Destination Information

Facility Name: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone #: _____ Clinician: _____
 Appointment Date: _____ Appointment Time: _____

Services Needed

Transportation

Level of service: () Ambulatory () Wheelchair () Stretcher () Gas Reimbursement
 Wheelchair Details: () Able to Transfer () Needs Lift () Manual () Electric Weight: _____
 Special Accommodations: _____
 Gas Reimbursement Driver: _____ Social Security Number: _____
 Street Address: _____
 City: _____ State: _____ Zip Code: _____

Lodging (provided for participant and one parent/guardian if participant is a child)

Dates Needed: _____

Meals (max two per day for child and two per day for one parent/guardian)

Dates Needed: _____

I _____ acknowledge that I realize that NEMT services should only be provided to treatments which MO HealthNet pays for and hereby declare, under potential penalty of MO HealthNet fraud, that to the best of my knowledge and belief the

Signature: _____ Date: _____
 Phone #: _____ Fax #: _____ Email: _____

Please fax this form to the LogistiCare Facility Department at 1-866-269-8875

Reviewed By: _____ Date: _____

() Ancillary Services Approved Lodging: _____
 Job Number _____

() Ancillary Services Denied Number of Meals Approved: _____

Reason: _____