



TRANSPORT REQUEST FORM

For SAME-DAY trips, call us at **901.808.0004**
All other trips, complete this form and fax or email.
If requested, we will send you a confirmation number.

FAX: (901) 614-2533

Email: RIDE@PrimeCareTransport.com

TRIP DATE: _____ **TIME:** _____ () Appointment Time **OR** () Pick-Up Time?

PATIENT NAME: _____ (First and Last Name) **ESCORT ?** (Y / N)

PATIENT DOB: _____ () Male () Female

WHERE PICK-UP? _____
(Facility Name or Street Address)

(Location inside Facility, Room #, Suite)

WHERE DROP-OFF? _____ (Street, Suite)

(City, State, Zip)

TYPE OF SERVICE: () Ambulatory () Wheelchair () Stretcher

IF Wheelchair, **BRING** Wheelchair? (Y / N)

NOTES: _____

Name of Person Placing Order: _____

AUTH # (if any): _____