Request for Transportation by Unlimited Transportation

Please print, complete and fax it to us (305) **225-1143**

REQUEST FROM

Company/Facility Name_____ Contact Name:_____

Phone: ( ) ext: Fax ( ) E-Mail Address_____

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Patient First Name:_ _____Last name:_____

Address_____ sex_____ D.O.B ____/_____/_____/

Phone:_____ Approximate Weight ____lb

Trip Information

Date of Order_____/____/___/ Date of Service___/____/_____/

☐ Wheelchair ☐ Stretcher Pick-up- Time_____:____

Appointment Time:_____:_____ or Return Time:_____:____ Will Call:_____

☐ Round Trip ☐ One Way ☐ Elevator ☐ wheelchair own

Please Provide one_____

Pickup Address:_____Phone:_____

Destination:_____Phone:_____

Direct Billing

Payment Methods. Must be completed by authorized person only

☐ **C**ash ☐ Check credit card#_ _____card type visa____ Master card_ ___Discover____

Exp Date_____ cardholder fist name_____ Last name_____

Cardholder address:_ _____City _____Zip_____

Note: Signature Required .Please downloaded form, complete, print and fax back to us.

I hereby authorized the above transportation.

Signature:_____

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