METROPLEX
MEDICAL TRANSPORTATION

Transportation Request Form

Fax to (682) 410-0166
Questions: (682) 410-0112

Date of Request: _____

Facility Name: _____ Contact Name: _____

Facility Address: _____ Contact Title: _____

Phone: _____ Email: _____ Fax: _____

Confirmation to be sent by: (circle one): Fax or Email

Client Information

(circle one): Male or Female

First Name: _____ Last Name: _____ Age: _____

Room#_____ Unit/Station: _____ Phone# _____ Ext_____

Appointment/Trip Details

Date of appt/pick up: _____ **Appt. time:** _____ **Need to wait:** Yes or No

Requested pick up time: _____ **Requested return time:** _____ or **Call when ready:** Yes or No

Name of Facility/Address

_____
_____
_____

Special Needs/Additional Information

_____
_____
_____

Physician/Dept: _____ Phone # _____

Escort: Yes or No **Trip:** One Way or Round-Trip **Type:** Appointment Dialysis Hospital discharge

Wheelchair: Yes or No **Transfer from Wheelchair**: Yes or No **Stretcher:** Yes or No

Steps: Yes or No (Number) _____ **Approx. Weight of Passenger:** _____

Bill to (circle one): Facility Private Pay **Payable by (circle one):** Invoice Credit Card Cash

Person Authorizing Payment: _____ _____ _____
(Must have Auth Signature on file) Print Name/Title Signature Date

For Company Use Only (please do not write below this line)

MMT Office:
Trip Confirmation Sent **Date & time:** _____

Vehicle #: _____

Trip# _____

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Please provide a list of your employees (include yourself if applicable) that are authorized to request billing for transportation services. Print name and include employee signature:

AUTHORIZED SIGNATURE

Name_____Title:_____

Phone No: _____ Email _____

Signature on File:_____Date:_____

AUTHORIZED SIGNATURE

Name_____Title:_____

Phone No: _____ Email _____

Signature on File:_____Date:_____

AUTHORIZED SIGNATURE

Name_____Title:_____

Phone No: _____ Email _____

Signature on File:_____Date:_____

AUTHORIZED SIGNATURE

Name_____Title:_____

Phone No: _____ Email _____

Signature on File:_____ Date:_____

This authorization is valid until **Metroplex Medical Transportation** receives written notice of Cancellation. This agreement comprises the entire agreement of the parties relating to the subject matter set forth herein and no provisions of this agreement can be waived except in writing.

Name and Signature of Officer Authorizing Direct Billing:

Print Name_____Title:_____

Phone No: _____ Email _____

Date of Authorization :_____

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Billing Authorization Form

TERMS AND CONDITIONS

By signing this document, I authorize **Metroplex Medical Transportation** to bill the facility/organization for all noted charges for transportation services that have been approved by the signature of the facility/organization's primary contacts listed below.

Invoices are payable directly to the transportation company and will include a copy of the Transportation Request Form for your records. **Metroplex Medical Transportation** has the authorization to contact the facility/organization on behalf of the transportation company to inquire about the status of the account. The billing is set up to process within 3 days of the completion of the trip. Contact **Metroplex Medical Transportation** within 5 business days of receipt of the invoice for clarification or adjustment.

Payment is due 30 days from the date of the invoice. Past due amounts will bear interest from due date at the lesser of 18% per annum of the highest rate permitted by applicable law. In the event of collection proceedings, the facility/organization completing this application, shall pay all collection and other costs incurred by **Metroplex Medical Transportation** and/or the transportation company. This includes, but is not limited to reasonable attorney's fees, whether litigation is commenced.

This authorization is valid until **Metroplex Medical Transportation** receives written notice of Cancellation. This agreement comprises the entire agreement of the parties relating to the subject matter set forth herein and no provisions of this agreement can be waived except in writing.

Contact Name _____ **Title** _____

Facility Name _____

Facility Address _____

_____

Signature _____ **Date** _____

Amount of Credit Requested: $_____
(Services will not be provided when this credit amount has been reached or exceeded)

Billing Address (if different from above)

_____

City: _____ State: _____ Zip Code: _____

Billing Dept. Phone _____ E-Mail Address_____

Please Check Type of Business: Hospital ____ Nursing Home ____ Dialysis _____

Other (please indicate) _____

Federal Tax ID No: _____ State Tax Id No: _____

Metroplex Medical Transportation
Office: (682) 410-0112
Fax: (682) 410-0166
Email: contact@metroplextrans.com
www.metroplextrans.com