Medica Provide-A-Ride℠ Transportation Request Form

This form is NOT intended for special transportation requests

Member Name: **Member DOB:** **Member Medica ID Number:** **Transportation Type: Medical ☐ EW ☐**	**Care Coordinator:** **Email:** **Phone Number:**
Description if EW:	

BUS TICKETS

Tickets will arrive at the mailing address within 5 days of submission.

Vendor	Mailing Address
☐ Metro Transit Access Pass ☐ Arrowhead ☐ Duluth Transit ☐ Other	**Address:** **Apt #:** **City:** **State:** **Zip Code:**

CAB SERVICE

Preferred Vendor: (If no preference leave blank)	**Date/s :** **M ☐ T ☐ W ☐ Th ☐ F ☐ S ☐ Sun ☐ Starting Date:**
Member Phone#:	**Appointment Time:** Round Trip ☐ One Way ☐ **Pick Up Time:**
Member Pick Up	**Location Name:** **Address, City, State & Zip code:**
Drop Off	**Location Name:** **Address, City, State & Zip code:**
2nd Drop Off	**Location Name:** **Address, City, State & Zip code:**
Final Drop Off **(If applicable, or different than pick up)**	**Location Name:** **Address, City, State & Zip code:**

Special Requests/ Comments

P-A-R Transportation Request Submission

Email (Preferred)	Fax
ProviderOversight@medica.com	952-992-3016

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