

Transportation Reservation Form

Reserve your transportation at least 48 business hours before your scheduled appointment.					
Member Information	First Name	Last Name	Date of Birth	Health First Colorado ID #	
	Phone Number		Email		
Pickup Information	Street Address				
	City / State / Zip Code				
	Pickup Notes (i.e. Gate Code, "Go to side", etc.)				
	Contact Phone		Will you be accompanied by an escort or personal care attendant?		
Dropoff Information	Facility Name				
	Facility Address (Street / City / State / Zip Code)				
	Medical Provider's Name				
	Time of Appointment	Date of Appointment	Time Driver should return:		
	Do you have access to a working vehicle?* <input type="radio"/> Yes <input type="radio"/> No		Name of Preferred Transportation Provider**		
Reason for Visit (Be Specific)					
Agreement & Signature	I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both. I certify under penalty of perjury, that I have obtained the information on the form from the patient or their representative, and the information provided is accurate to the best of my knowledge.				
	Printed Name		Relation to Member		
	Signature		Date		
For IntelliRide Use	Reservation Status <input type="radio"/> Approved <input type="radio"/> Denied		Staff Initials	Received	Entered

***If yes, you may qualify for mileage reimbursement**

**** Assignment of trips to a preferred transportation provider is not guaranteed**

Please send completed form to: Fax (720) 302.0106 | Email: us.coclinicalcoordinator@transdev.com