## HealthCare Access for Services Request Form
## **UPCOMING APPOINTMENTS**

**Appointments out of the local service area must be prior authorized to be reimbursed. Please turn in requests Five (5) business days PRIOR to date of appointment.**

**NOTICE TO CLIENTS:**

Complete the information below. Attach a copy of the medical appointment and referral for the medical appointment out of the area

**Today's Date:** _____

**Name of Patient:** _____ **Patient Date of Birth:** _____

**Address:** _____

**Appointment Date:** _____ **Time:** _____

**Location of Appointment:**

_____

**Phone number where you can be reached:** _____

******This must be a valid phone number! We must be able to reach you to discuss your request. In some cases you may not be eligible for everything you have requested. ******

**Services Requested:** (Please check all that apply and add dates for lodging and meals)

**Lodging:** _____ **Meals:** _____ **Mileage:** _____ **Volunteer Driver**____
**Dates** **Dates** **local bus service** ____

Name of adult accompanying child: _____

**Signature of person requesting services:** _____