Medica

Medica Provide-A-Ride℠ Elderly Waiver (EW) Transportation Authorization Form

Member name: **Member DOB:** **Medica ID number:**	**Care Coordinator:** **Email address:** **Phone number:**

Location and Frequency (please list): (Example: 3x month – Target 123 Medica ave, Minnetonka MN 55305)

Time Frame (The time frame of EW requests must run within the member's EW timeline)**:**

Affirmation: By checking the following box, I affirm that this member is open to the elderly waiver, that I have documentation of and budgeted for the need of these non-medical rides, and by doing so I am subject to audit by Medica for this member's or any members' care plan in my case load.

Please note:
Incomplete requests will not be processed.

P-A-R Transportation Request Submission

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

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