

Medica Provide-A-RideSM 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:	
<p>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 am subject to audit by Medica for this member's or any members' care plan in my case load.</p> <div style="text-align: right; margin-right: 50px;"> <input type="checkbox"/> </div>	
<p>Please note:</p> <ul style="list-style-type: none"> The time frame of EW requests must run within the member's EW timeline. Incomplete requests will not be processed. 	

P-A-R Transportation Request Submission

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