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 :** **Or days of week:** **M☐ T☐ W☐ Th☐ F☐ S☐ Sun☐ Starting Date:**		
Member Phone#:	**Appointment Time:**	**Pick Up Time:**	Round Trip ☐ One Way ☐
Member Pick Up	**Address :** **Location Name:**	**City & zip code:**	
Drop Off	**Address :** **Location Name:**	**City & zip code:**	
2nd Drop Off **(If applicable)**	**Address :** **Location Name:**	**City & zip code:**	
Final Drop Off **(If applicable, or different than pick up)**	**Address :** **Location Name:**	**City & zip code:**	

Special Requests/ Comments

P-A-R Transportation Request Submission

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

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