NEUROVERSION
Break the cycle of pain

Medicaid Travel Request Form

Completion of this form does not guarantee Medicaid travel vouchers will be provided. For cab vouchers, provide one week's notice; for hotel and/or air travel, two weeks' notice. Allow 24-48 hours for confirmation of receipt of this form, if you do not receive phone call within this time, contact the office.

Today's date: ________________

Regarding (Patient Name):

First Name ________________ Last Name ________________

Date of Birth: ________________

Address:

Street Address

Street Address Line 2

City ________________ State ________________ Zip ________________

Phone number: ________________

Medicaid travel requested for:

☐ Follow-up visit
☐ Procedure
☐ Multiple appointments
☐ Other

Please elaborate if "Other": ________________

Date of NEXT appointment: ________________

I am: ☐ Patient ☐ Guardian