



## Facility Ride Requests

Facility Name: \_\_\_\_\_

Facility Phone #: \_\_\_\_\_

Contact name: \_\_\_\_\_

Email request to: [RideCare@HealthPartners.com](mailto:RideCare@HealthPartners.com) or Fax to: 952-883-9660

Member Name: \_\_\_\_\_

Member ID#: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Best phone # to reach member: \_\_\_\_\_

Pick up address	Destination Name	Destination Address	Appointment Date	Appointment Time	Additional Riders? Name, if yes.	Mode of transportation Please Specify: <ul style="list-style-type: none"><li>• Unassisted</li><li>• Assisted</li><li>• Wheelchair</li><li>• Stretcher</li></ul>

Return ride required:  If alternative final address: \_\_\_\_\_

Driver/vehicle notes: \_\_\_\_\_