Ceeccil Quality Care Transportation LLC
2720 E Yampa St, Suite 2A, Colorado Springs, CO 80909
Monday – Saturday | 04:00 AM – 10:00 PM
Phone: (720) 669-0696 | Fax: (720) 615-8666
Email: qa@ceeccil.com | Website: www.ceeccil.com

24/7 Customer Service Call Center – Support: 888-906-0669

Trip Reservation Form

Reserve your NEMT transportation at least 2 business days before your scheduled medical appointment.

Full Name: _____

Address: _____

Phone: _____

Email: _____

Preferred Method of Contact (Phone, SMS, Email): _____

Languages Spoken (English, Spanish, Other than English or Spanish): _____

Date of Birth: _____

Whom may we thank for referring you to our practice? _____

Insurance Company Name: _____ Health Insurance ID: _____

Types of NEMT or Level of Service (Mobility/Ambulatory Vehicle, Wheelchair Van): _____

Will you be accompanied by an escort? If yes, full name: _____

Reservation Type (One-way trip, One-way trip with a stop, Round trip, Round trip with a stop, Discharge Transportation):
_____.

Appointment Date: _____
Appointment Time: _____
Reason for Visit: _____
Transport Date: _____
Pick up Time: _____

	Pick-up Address:	Destination Address	Medical Facility Name
(1)			
(2)			
(3)			
(4)			

Is the passenger a minor? (Yes/No) _____
Number of Passengers: _____
Traveling with children and infants? (Yes/No) _____
Your Trip Notes: _____.

Electronic Communication Consent:
----- I consent that Ceeccil Quality Care Transportation LLC can provide its services and communicate with me via mobile phone, messages, e-mail, and any online communications, provided these communications comply with privacy regulations. And I acknowledge that I was provided a copy of the Electronic Communication Consent.
----- Decline to consent.

Notice Of Privacy Practices Acknowledgement:
----- I acknowledge that I was provided a copy of the Notice of Privacy Practices.
----- Decline to acknowledge.

Privacy Notice Acknowledgement:
----- I acknowledge that I was provided a copy of the Privacy Notice Acknowledgement.
----- Decline to acknowledge.

Notice of Non-Discrimination/Anti-Harassment Acknowledgement:
----- I acknowledge that I was provided a copy of the Notice of Non-Discrimination/Anti-Harassment Acknowledgement.
----- Decline to acknowledge.

Insurance Verification and Authorization and Financial Responsibility Disclosure:
----- Agree.
----- Decline.

Agreement:
------ I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both. I certify under penalty of perjury, that I have obtained the information on the form from the patient or their representative, and the information provided is accurate to the best of my knowledge.

Printed Full Name: _____

Signature: _____ **Date:** _____