CARE-A-VAN PASSENGER TRIP MANIFEST

Pay Method: **PA/Audit #**

Passenger Iinformation

Name

Wheelchair ☐

Pick Up Address:

No. of Escorts:

Pick Up City:

Passenger Notes:

Social Security #:

DOB:

Phone Number:

Appointment Information

Driver:

Appt. Time:

Notes

PickUpTime:

FacilityName:

FacilityPhone:

Facility Address:

Return Pick Up Information

Return Driver: **Estimated Return Time**

Final Destination:

Our drivers do not always wait at the facility. Please provide an estimate time of return for your patients ride home.

_____

Health Care Provider Signature:_____ ***Date:***_____

Passenger Declaration (To be completed by all passengers boarding the automobile)

I agree to indemnify and hold harmless CARE-A-VAN, The Health Care Financing Administration, the State of New Mexico, the Department of Health, and any of its agencies, and the Medicaid Program against any and all liability, loss, damage, cost or expenses which I may sustain , incur or be required to pay because I was injured, died or sustained property loss or damage whiled being transported or because I, as a passenger, inured another person or damaged the property of another person while being transported. I agree to notify CARE-A-VAN within 5 days if any legal actions are brought against them.

Passenger Signature:_____ ***Date:***_____

Attendant 1 Signature:_____ ***Date:***_____

Attendant 2 Signature:_____ ***Date:***_____

Driver Signature:_____ ***Date:***_____

Time & Odometer Readings

1st Pick Up Time	1st Pick Up Odometer	1st Drop Off Time	1st Drop Off Odometer
2nd Pick Up Time	2nd Pick Up Odometer	2nd Drop Off Time	2nd Drop Off Odometer

COMPLETE IN CASE OF RELAY!!!

3rd Pick Up Time	3rd Pick Up Time	3rd Pick Up Time	3rd Pick Up Time
4th Pick Up Time	4th Pick Up Time	4th Pick Up Time	4th Pick Up Time