SBD SOLUTIONS

# TRANSPORTATION REQUEST FORM

**REQUESTOR:** **PHONE NUMBER:**

## CLAIMANT INFORMATION

| NAME | | TELEPHONE |
|---|---|---|
| | | |
| **DATE OF INJURY** | **DOB** | **SSN** |
| | | |

## TRIP INFORMATION

| TYPE OF TRANSPORTATION | DAY(S) OF PICK UP |
|---|---|
| ☐ A ☐ W ☐ B ☐ S/G ☐ BLS ☐ ALS ☐ CCT ☑ Air | M ☐ T ☐ W ☐ TH ☐ F ☐ SAT ☐ SUN ☐ |
| ☐ ROUND TRIP/ WILL CALL RETURN<br>☐ ONE WAY ONLY<br>☐ WAIT AND RETURN (DRIVER TO STAND BY) | TIME OF PICK-UP: _____<br>DATE OF PICK-UP:_____<br>TIME OF APPT.: _____ |
| **PICK UP LOCATION** | |
| | |
| **DROP OFF LOCATION** | |
| | |

## CARRIER INFORMATION

| CARRIER NAME | CARRIER ADDRESS |
|---|---|
| | |
| **CLAIM NUMBER** | AUTHORIZED BY |
| | |
| ADJUSTER INFORMATION | REFERRED BY |
| NAME: | |
| PHONE: | **COMMENTS:** |
| EMAIL: | |