Lextran

200 West Loudon Avenue
Lexington, KY 40508
859-244-2030 • lextran.com

Healthcare Provider
Medical Verification Form

A healthcare provider may also fill out this Medical Verification Form online at www.biokinetix.com/lextran.

Please mail to: ***Kort Physical Therapy***
Attn: Lextran Paratransit
1650 Bryan Station Rd, Ste 122
Lexington, KY 40505

Fax to: (717) 635-3720

Applicant Name: Date of Birth:

1. **Please list medical diagnoses or conditions that prevent the applicant from using the Lextran bus independently:**

_____

_____

2. **Please describe how the applicant's disability prevents them from using Lextran fixed route buses independently:**

_____

_____

_____

3. **Date of onset: _____**

4. **Is the applicant's functional limitation permanent? _____**

   If no, what is the expected duration: _____

5. **Does the applicant need a Personal Care Attendant (PCA)?**

   If yes, please explain: _____

I certify that I am licensed/certified and am currently treating the applicant listed above.

I certify that all information provided in this application is a fair representation of the applicant's disabilities (or health conditions) and is true and correct.

I understand that the information provided will be used for the purpose of determining the applicant's eligibility for Lextran Wheels paratransit service.

_____

Healthcare Provider Signature Date

Clearly print your contact information below:

Lextran

Name: _____ Board Certification # or License #: _____
Phone Number: _____ Fax Number: _____
Business Address: _____