



To all Medicaid Bus Pass Clients:

You will need to fill out this form each month to determine if you have enough appointments to receive a bus pass.

Client's Name _____

Address: _____

How many times a month will you use your pass? _____

Which month are you requesting a pass for? _____

Medicaid Number: _____

Doctor appointment info:

Dr. Name: _____

Dr. Name: _____

Dr. Phone: _____

Dr. Phone: _____

Dr. Address: _____

Dr. Address: _____

Appointment Date: _____

Appointment Date: _____

Dr. Name: _____

Dr. Name: _____

Dr. Phone: _____

Dr. Phone: _____

Dr. Address: _____

Dr. Address: _____

Appointment Date: _____

Appointment Date: _____

You will need to complete this form completely including phone numbers and dates. We verify appointments before we issue any bus passes.

Fax or mail completed form to:
Community Transportation Services
13825 Icot Blvd #613
Clearwater, FL 33760
FAX: (727) 544-0171
Phone: 727-545-2100