



## Wisconsin Medicaid and BadgerCare Plus Meals and Lodging Request Form

MEMBER INFORMATION		
Member's Last Name:	Member's First Name:	
Name of Parent or Medically Necessary Escort:	Member's Phone Number:	
Member's Street Address:		
City:	State:	Zip:
ForwardHealth ID:	Date of Birth:	
DESTINATION INFORMATION		
Facility Name:	Facility Phone:	
Street Address:		
City:	State:	Zip:
Reason for Trip/Appointment:	Admit? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Appointment/Admit Date:	Appointment/Admit Time:	
SERVICES REQUESTED		
Lodging	Date(s) Needed:	
Meals	Number of Days:	<b>Please note:</b> Authorizations for member's meals/lodging are valid for a maximum of four weeks without re-verification of need. Veyo will initiate the re-verification process.
PERSON COMPLETING FORM		
Name:	Title:	
Phone Number:	Fax Number:	

**Mail or fax the completed form to Veyo at:**

**Mail:** Veyo, Attention: Clinical Coordinator, 8383 Greenway Blvd, Suite 400, Middleton, WI 53562

**Fax:** 888-506-7708, Attn: Clinical Coordinator