BlueRide℠ Transportation Approved Scheduler Request Form

For County Case Workers and Care Coordinators	
Reporting Agency (Please print.)	**Member**
Name: ______	Name: ______
Agency: ______	Blue Cross member ID: ______
Email: ______	Date of Birth: ______
Phone: ______ Fax: ______	Phone: ______
Approved Scheduler 1	**Approved Scheduler 2**
Name of Approved Scheduler: ______	Name of Approved Scheduler: ______
Phone: ______	Phone: ______
Email: ______	Email: ______
Relationship to the Member: ______	Relationship to the Member: ______

Check applicable box:

☐ Foster child placed with county

☐ Authorized person to schedule

I certify that the approved scheduler can schedule rides on the member's behalf.

Signature: ______ Title: ______ Date: ______

Print Name: ______

Submit completed form to BlueRideSTS@bluecrossmn.com.

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