



Paratransit Request Form

First Name: _____

Last Name: _____

UID: _____

Directory ID: _____

Phone number: _____

Email: _____

Local Mailing Address: _____

Lift Assistance: **Yes** **No**

The UHC will give the individual two weeks of access to paratransit services. If the individual needs more than two weeks of service, they will need a letter from the medical provider stating the reason and how long services are needed for.

Please fax all paratransit requests to 301-314-5234.