NETSPAP STANDING PRIOR APPROVAL FORM

ALL BLANKS MUST BE ACCURATELY COMPLETED. FORMS SENT TO FIRST TRANSIT MUST HAVE SENDER'S NAME OR FAX NUMBER PRINTED AT THE TOP OF EACH TRANSMITTED PAGE.

Requesting Organization Information

Your Organization Name

Date & Time You Initiated Request

A.M.

P.M.

Your Name

Title/Relationship

Fax Number

Your Phone Number

Physician Name

Phone Number

Participant Information

Participant Name: (Last) (First) (RIN)

Recipient Identification Number

Trip Information

New Trip Renewal

Beginning Dates

Ending Dates

(All services can only be approved for a period up to 6 months).

Dialysis Chemotherapy Behavioral Health Services Radiation Therapy Physical Therapy Speech Therapy Occupational Therapy

Other

Appointment Days

Actual Appointment Time

Mon Tue Wed Thu Fri Sat Sun

Please indicate the total trips per week:

Origin – Destination Information

Origin Location Name

Phone Number

Participant’s Pick-up Address

Pick-up City County State Zip Code

Referring Physician’s Name: Referring Physician’s Phone Number:

Refrigerator Provider Name Medicaid Provider ID# or License Number:

Destination Location Name Most Direct Phone # to validate request:

Drop-off Location Address

Drop-off City County State Zip Code

Non-Emergency Transportation (NET) Provider

Company Name Phone Number

Category of Service Options: (Please select the most economical category of service that will meet the participant’s needs.)

Private Auto Service Car or Taxi Medicar Non-Emergency Ambulance

Fixed Route (Bus/Train) Employee Attendant Non-Employee Attendant Wheelchair Stretcher BLS

Employee Attendant Non-Employee Attendant ALS

Non-Employee Attendant Oxygen/Supplies

Reason for Trip Detailed (Please provide the Primary and Secondary Diagnosis, Current Treatment Plan and any other pertinent Information)

Agreement and Signature

I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both. I certify, under penalty of perjury, that I have obtained the information on this form from the participant (or his or her representative), and the information provided is accurate to the best of my knowledge. I understand for prior approval ambulance transports, a Certificate of Transportation Services (CTS) (available on www.netspap.com) or an equivalent doctor’s statement is required, and for post approval ambulance transports, Run Report(s) and a CTS or equivalent doctor’s statement is required. If First Transit does not receive required documentation within 2 business days of the initial request date, the request will be denied. DENIED REQUESTS CAN ALWAYS BE RESUBMITTED WITH THE REQUIRED DOCUMENTATION.

Requesting Person’s Signature Date Signed

NETSPAP Standing Prior Approval Form – FT Public (02-24-2016)