☐	APPROVED
☐	Denied: Reason Code
☐	Returned/ Incomplete

RTN:

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.

First Transit
799 Roosevelt Rd, Bldg 4, Suite 200
Glen Ellyn, Illinois 60137
www.netspap.com
(866) 503-9040 Toll Free
(630) 873-1450 Fax

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: ______________________ Recipient Identification Number ______________

(Last) (First) (RIN)

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: ______________

Medical 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**

☐ **Fixed Route** (Bus/Train)

☐ **Service Car** OR **Taxi** ☐
- ______ Non-Employee Attendant
- ______ Employee Attendant

☐ **Medicar**
- ______ Wheelchair ______ Stretcher
- ______ Non-Employee Attendant
- ______ Employee Attendant

☐ **Non-Emergency Ambulance**
- ______ BLS
- ______ ALS
- ______ 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