☐ **APPROVED**
☐ Denied: Reason Code _____
☐ Returned/ Incomplete
RTN

NETSPAP SINGLE TRIP FORM

ALL BLANKS MUST BE ACCURATELY COMPLETED AND LEGIBLE. INCOMPLETE FORMS MAY BE RETURNED.

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
REGISTERED NURSE MANAGER

Requesting Organization Information

Requesting Organization Name _____ Today's Date _____

Requesting Person's Name _____ Title/Relationship _____

Fax Number _____ Call Back Number _____

Participant Information

Participant Name _____
(Last) (First)

Recipient Identification Number (RIN) _____ Date of Birth _____

Trip Information

Date _____ Specific Appt. Time _____ A.M. P.M. Return Pick-up Time _____ A.M. P.M.

☐ One Way ☐ Round Trip ☐ Other _____ If this is a correction request, write RTN of previous trip: _____

Reason for Trip

(Be specific) _____

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 _____

Answer ALL of the following questions

How does the participant currently get to the grocery store, laundromat, church, etc.? _____

Does the participant have a car? _____ Is there a relative or friend who can take the participant to his/her appointment? _____

Is the participant able to travel by fixed route transportation (bus or train)? (If no, explain) _____

Is the participant in need of a wheelchair or stretcher? (If yes, explain) _____

List any medical conditions, diagnoses, or reasons which explain the requested category of service and/or need for attendants. _____

Category of Service Options:

(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

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 an equivalent doctor's statement is required. **DENIED REQUESTS CAN ALWAYS BE RESUBMITTED WITH THE REQUIRED DOCUMENTATION.**

_____ _____
Requesting Person's Signature Date Signed

Revised 1/4/10