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

NETSPAP STANDING PRIOR APPROVAL 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

Your Organization Name _____ Today's Date _____

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 SPA ☐	*Renewal* ☐

Beginning Dates _____ Ending Dates _____

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

☐ Other _____

Appointment Days

Mon	*Tue*	*Wed*	*Thu*	*Fri*	*Sat*	*Sun*
☐	☐	☐	☐	☐	☐	☐

Specific Appt. Time _____ Return Pick-up Time: _____ Indicate the Number of 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

(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

Detailed reason for trip

(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