

<input type="checkbox"/>	APPROVED
<input type="checkbox"/>	Denied: Reason Code _____
<input type="checkbox"/>	Returned/ Incomplete
RTN	

# NETSPAP SINGLE TRIP FORM

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



## 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.)

<input type="checkbox"/> Private Auto	<input type="checkbox"/> ← Service Car or Taxi → <input type="checkbox"/>	<input type="checkbox"/> Medicar	<input type="checkbox"/> Non-Emergency Ambulance
<input type="checkbox"/> Paratransit or Fixed Route	_____ Non-Employee Attendant	_____ Wheelchair _____ Stretcher	_____ BLS
	_____ Employee Attendant	_____ Non-Employee Attendant	_____ ALS
		_____ Employee Attendant	_____ 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](http://www.netspap.com)) or an equivalent doctor's statement is required, and for post approval ambulance transports, Run Report(s), a Physician Certification Statement (PCS), 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 \_\_\_\_\_