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

NETSPAP STANDING PRIOR APPROVAL FORM

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

transdev
the mobility company
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 _____ P.M. A.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
(All services can only be approved for a period up to 6 months).

_____ Ending Dates

☐ 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**

☐ **Paratransit or Fixed Route**

☐ **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 Physician Certification Statement (PCS), 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 Transdev 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