How to submit the request to First Transit for an RTN:

Single Trip:
Option 1: Book the request by phone by calling (866) 503-9040
Option 2: Fax a Single Trip Form to (630) 873-1450
Option 3: Mail a Single Trip from to 799 W Roosevelt Rd., Bldg 4, Suite 200, Glen Ellyn Il 60137
Option 4: Participants, NET Providers, Dialysis Centers and Long Term Care Facilities may book the trip by PassPORT

Standing Prior Authorization:
Option 1: Fax a Standing Prior Authorization (SPA Form) to (630) 873-1450
Option 2: Mail a Standing Prior Authorization (SPA Form) to 799 W. Roosevelt Rd., Bldg 4, Suite 200, Glen Ellyn, Il 60137
Option 3: Participants, NET Providers, Dialysis Centers and Long Term Care Facilities may book the trip by PassPORT

- A CTS form may be requested by First Transit to support the level of service requested for the date of service completed by a licensed, medical professional.

Information needed to obtain an RTN:

Name of the Individual (First and Last)
Phone Number
Address (Street, City, Zip)
RIN Number
Ambulatory or Wheelchair
Date of Appointment
Time of Appointment
Pick Up Address
Drop off Address (This will be the Facility address)
Doctor's Name (First and Last)
Facility Name
Facility Address
Doctor's Office Phone Number
Reason for the Trip (this needs to be specific)

***** If the Trip is over 50 miles you MUST have a Referring Doctor's Name and Phone Number******

☐ 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: ______________________ (Last) (First) Recipient Identification Number ______________________ (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

☐ 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

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 ______ Return Pick-up Time ______

☐ 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