Non-Emergency Transportation Services Prior Authorization Program (NETSPAP)
First Transit Trip Authorization Request

HFS has contracted First Transit to help them manage the NETSPAP program. First Transit is not a transportation company. First Transit receives all your requests for transportation and then decides if the trip can be approved or if it has to be denied based on the rules given by HFS. This process can take a few days so it's always a good idea to submit your request at least a week before your appointment. If your request is **approved**, you can arrange your trip with a transportation company that's enrolled in the program.

HOW TO REQUEST MEDICAL TRANSPORTATION

1. By Phone – Call First Transit at (877) 725-0569 and speak to a Customer Service Representative.
2. By Fax – Fax your trip request form to (630) 873-1450.
3. By Mail – Mail your trip request form to First Transit, Inc., 799 W. Roosevelt Road, Building 4, Suite 200, Glen Ellyn, IL 60137.
4. Your doctor's office might be willing to do it for you. The First Transit phone number for all providers is (866) 503-9040.
5. Online (coming in the future) – Fill out your trip request form online and click on "Submit".

Please keep in mind that you may need to call First Transit a few days after you submit your request to check on the status.

Once you have your RTN call NCAT at 833-433-6228 to schedule your ride as soon as possible. Be sure to tell the Reservation Specialist that you have an RTN.

INFORMATION NEEDED TO OBTAIN AN RTN (Request Tracking Number)

- Your Medicaid ID number (9-digit Recipient Identification Number)
- Your name (if someone else is calling for you we may need an OK from you before we can continue talking to them)
- Information on how you have been getting to your medical appointments before using this service
- If there are medical or non-medical reasons why you cannot use public or other transportation
- The date and time of the appointment
- Your pick-up address and phone number
- The address and phone number where you are going
- The name of the office/clinic/hospital where you are going
- The name of the doctor you will be seeing
- The general reason for your doctor's visit
- If you use a walker, wheelchair, or cane
- If you can travel by yourself
- The name of your preferred transportation company (City of Ottawa – NCAT)

HOW LONG WILL IT TAKE TO GET AUTHROIZATION?

While most trips can be approved or denied at the time of the phone call, some requests need a longer processing time, such as:

- Appointments to Behavioral Health Services (for example visiting a psychiatrist, going to psychotherapy or other mental health related issues): 5 business days.
- Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), and Aqua therapy (AT): 5 business days.
- Long Distance Trips: 7 business days.

If you call to request authorization for your trip less than a week in advance, First Transit may not be able to approve your trip.

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

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____ ______________________
Requesting Person's Signature Date Signed