N.E.T. MEDICAL PROVIDER VERIFICATION

NET Recipient Name _____

Name of Medical Provider _____

Address of Medical Provider _____

Date of Appointment _____ **Time of Appointment** _____

Pharmacy Name _____ Date prescription _____
(if picking up a prescription) Filled

Driver's Signature _____

NET Client's Signature _____

Medical Provider's Signature _____
(This can be a nurse, receptionist, druggist, etc. This signature is to verify that the client was seen on this date and the provider will be billing Medicaid/Managed Care Plan for the service provided.)

** FAILURE TO HAVE VERIFICATION COMPLETED ENTIRELY WILL RESULT IN NON-PAYMENT OF THE TRANSPORTATION! Eff. August 1, 2014

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