

**TUSCARAWAS COUNTY JOB & FAMILY SERVICES  
NON-EMERGENCY TRANSPORTATION (NET) VERIFICATION**

NET Recipient Name: \_\_\_\_\_

Name of Medical Provider: \_\_\_\_\_

Address of Medical Provider: \_\_\_\_\_

**Date of Appointment:** \_\_\_\_\_ **Time of Appointment:** \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Date Prescription Filled: \_\_\_\_\_  
(if picking up a prescription)

**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!**

BO 52 (04/17/2008/bg)

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