

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

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

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

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

---

**The above information may be photocopied; however, the information below may not be photocopied.**

---

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

**Driver's Signature:** \_\_\_\_\_

**NET Client's Signature:** \_\_\_\_\_

**Medical Provider's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

(This can be a nurse, receptionist, doctor, 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 (05/09/2011/bg)

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

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

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

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

---

**The above information may be photocopied; however, the information below may not be photocopied.**

---

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

**Driver's Signature:** \_\_\_\_\_

**NET Client's Signature:** \_\_\_\_\_

**Medical Provider's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

(This can be a nurse, receptionist, doctor, 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 (05/09/2011/bg)