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

I, _____, authorize the release of information between Tuscarawas County Job and
NET RECIPIENT NAME

Family Services, 389 16th Street, SW, New Philadelphia, Ohio 44663, and _____
NAME OF MEDICAL PROVIDER (Doctor, Dentist, etc.)

at _____ _____
NAME OF MEDICAL FACILITY (Union Hospital, CMH, etc.) ADDRESS OF MEDICAL PROVIDER

The above information may be photocopied; however, the information below <u>may not</u> be photocopied.

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

Driver's Signature: _____

NET Client's Signature: _____

Medical Provider's Name: _____ **Med Provider's Phone #:** _____
(please print)

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 (12/13/2013/vb)

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