Standing Prior Approval (SPA) Form

All blanks must be accurately completed and legible. Incomplete forms may be returned

Email: mcotransportation@firstgroup.com
Phone: 630.403.3210
Fax: 888.493.5146

Member Name: ______________________

Member ID/ RIN: ___ ___ ___ ___ ___ ___ ___ ___ ___ Date of Birth: ______________

Requestor's Name ______________ Today's Date ______________

Requestor's Relationship/Title ______________ Call Back Phone No. ______________

Requesting Organization ______________ Fax Number ______________

Trip Information

New SPA ☐ | **Renewal** ☐

Beginning Date ______________ Ending Date ______________ ☐ Round-Trip ☐ One-Way ☐ Other

Appt. Time ______________ Return Time: ______________ Appt. Days

Mon	***Tue***	***Wed***	***Thu***	***Fri***	***Sat***	***Sun***
☐	☐	☐	☐	☐	☐	☐

No. of Trips Per Week ______________

☐ Dialysis | ☐ Chemotherapy | ☐ Behavioral Health Services | ☐ Radiation Therapy | ☐ Physical Therapy | ☐ Speech Therapy | ☐ Occupational Therapy

☐ Other Trip Reason: ______________

Detailed Reason for Trip:
(Provide the Primary and Secondary Diagnosis, Current Treatment Plan and any other pertinent information)

Origin

Identifier/Name ______________

Phone No. ______________

Address ______________

City ______________ State ______________

Zip Code ______________ County ______________

Referring Dr's Name ______________

Referring Dr's Phone No. ______________

Destination

Identifier/Name ______________

Phone No. ______________

Address ______________

City ______________ State ______________

Zip Code ______________ County ______________

Medical Provider Name: ______________

Most Direct Phone No. to Validate ______________

Category of Service Options **(Select the most economical category of service that will meet the member's needs)**

☐ Private Auto (055)

☐ Fixed Route
(Bus/Train)

☐ Service Car (054) OR Taxi (053)
____ Non-Employee Attendant
____ Employee Attendant

☐ Medicar (052)
____ Wheelchair ____ Stretcher
____ Non-Employee Attendant
____ Employee Attendant

☐ Non-Emergency Ambulance (051)
____ BLS
____ ALS
____ Oxygen/Supplies

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 the information provided on this form is accurate to the best of my knowledge. I understand for prior approval ambulance transports, a Certificate of Transportation Services (CTS) or an equivalent doctor's statement is required. If First Transit does not receive required documentation prior to the transport, the request will be denied.

______________________________ ______________

Requesting Person's Signature Date Signed