

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)  
**Non-Emergency Medical Transportation  
(NEMT) for PASRR Program Request**

Date: \_\_\_\_\_

TO: \_\_\_\_\_, NEMT Broker      FAX Number: (\_\_\_\_) \_\_\_\_\_

NEMT Broker Look-up: <http://www.hca.wa.gov/assets/billers-and-providers/regionmap.pdf>

FROM (DDA Region): \_\_\_\_\_

Name of PASRR Assessor: \_\_\_\_\_      Phone Number: (\_\_\_\_) \_\_\_\_\_

**Section 1. Client Information**

LAST NAME	FIRST NAME	PROVIDER ONE ID NUMBER	DATE OF BIRTH
ADDITIONAL CONTACT	PHONE NUMBER (WITH AREA CODE)	ORGANIZATION	
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Will support person ride with the individual?  Yes  No

PICK-UP ADDRESS (EXACT ADDRESS / ENTRANCE)

DROP-OFF ADDRESS (EXACT ADDRESS / ENTRANCE)

RECURRING APPOINTMENT  
 Yes  No

APPOINTMENT START TIME  
:  AM  PM

APPOINTMENT END TIME  
:  AM  PM

TRANSPORTATION START DATE

TRANSPORTATION END DATE

SPECIAL NEEDS / COMMENTS

**Section 2. Certification**

Client is Medicaid Eligible.

Client needs transportation to an alternate location to receive PASRR Specialized Add-on Services.

SIGNATURE

DATE

PRINT NAME