



Division of Medicaid and Long-Term Care  
 Individual Transport and Escort/Attendant  
 Provider Record of Service

Submit form to:  
 AMR Nebraska NET  
 6200 S. Syracuse Way, Box 200  
 Greenwood Village, CO 80111  
 (855) 219-1091 phone (888) 294-8643 fax  
 AMRNebraskabilling@emsc.net

Client's Name	Client's DOB	Transportation Name	Transportation Number

INTERNAL USE								
Trip #	Program Type	Appt. Date	Trip Start Time	Pick Up Name and Address	Destination Name and Address	Trip End Time	Total Escort Hours	Medical Provider's Signature

By signing this form, the claimant certifies that the information contained in this Record of Service is accurate and all services provided were in compliance with Department of Health and Human Services Nebraska Administrative Codes Titles 471, 473, and 480, whichever applicable. The claimant is aware that a false claim may result in prosecution for fraud. Under penalty of applicable Federal and State laws, I certify that representation herein are true and complete, and that no additional or duplicate payment will be claimed.

\_\_\_\_\_  
 Client or Representative Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Transportation Provider Signature

\_\_\_\_\_  
 Date

Internal Use (Client ID)	
MMIS	
SSAD	

Internal Use (Provider ID)	
MMIS	
SSAD	