Medicaid Transportation Provider Documentation

North Carolina _____County Department of Social Services

Organization Information

Organization Name as shown on income tax return_____EIN_____

Doing Business As (DBA) information

DBA Name_____EIN_____ Former DBA Name(s)_____EIN_____

Former DBA Name(s)_____EIN_____

Years Doing Business under Current Name_____Years Doing Business under Previous Name(s)_____

Ownership Information

How would you describe the ownership? (circle one)

Sole Proprietor Partnership Single –Owner LLC Corporation City/Municipality Non-Profit

For Corporation, Partnership, or Non-Profit: P lease provide ownership information for each owner who has direct or indirect ownership or control interest of 5% or more in the organization or entity.

Owner 1

Full Name (Last, first, Middle)_____ SSN or EIN_____

Date of Birth (MM/DD/CCYY)_____Business Relationship to NEMT Provider_____

Familial Relationship to NEMT Provider (Mother, Father, Sister, Brother, None, etc.)_____

Owner 2

Full Name (Last, first, Middle)_____ SSN or EIN _____

Date of Birth (MM/DD/CCYY)_____Business Relationship to NEMT Provider_____

Familial Relationship to NEMT Provider (Mother, Father, Sister, Brother, None, etc.)_____

Owner 3

Full Name (Last, first, Middle)_____ SSN or EIN_____

Date of Birth (MM/DD/CCYY)_____Business Relationship to NEMT Provider_____

Familial Relationship to NEMT Provider (Mother, Father, Sister, Brother, None, etc.)_____

Owner 4

Full Name (Last, first, Middle)_____SSN or EIN _____

Date of Birth (MM/DD/CCYY)_____Business Relationship to NEMT Provider_____

Familial Relationship to NEMT Provider (Mother, Father, Sister, Brother, None, etc.)_____

Managing Relationships

As required by 42 CFR 1002.3, Non Emergency Medical Providers must disclose the following for each individual officer, director, managing employee (general manager, business manager, administrator) and Electronic Funds Transfer (EFT) authorized individual. Failure to provide the required information may result in a denial for participation.

Relationship 1

Full Name (Last, first, Middle)_____ Social Security Number_____

Date of Birth (MM/DD/CCYY)_____Business Relationship to NEMT Provider_____

Familial Relationship to NEMT Provider (Mother, Father, Sister, Brother, None, etc.)_____

Relationship 2

Full Name (Last, first, Middle)_____ Social Security Number_____

Date of Birth (MM/DD/CCYY)_____Business Relationship to NEMT Provider_____

Familial Relationship to NEMT Provider (Mother, Father, Sister, Brother, None, etc.)_____

Relationship 3

Full Name (Last, first, Middle)_____ Social Security Number_____

Date of Birth (MM/DD/CCYY)_____Business Relationship to NEMT Provider_____

Familial Relationship to NEMT Provider (Mother, Father, Sister, Brother, None, etc.)_____

Relationship 4

Full Name (Last, first, Middle)_____ Social Security Number_____

Date of Birth (MM/DD/CCYY)_____Business Relationship to NEMT Provider_____

Familial Relationship to NEMT Provider (Mother, Father, Sister, Brother, None, etc.)_____

By my signature, I attest that none of the individuals identified above have ever been convicted of:

- A criminal offense related to the delivery of an item or service under Medicare, Medicaid, or any state health care program;
- Medicare/Medicaid or any other healthcare program fraud;
- A conviction related to patient/client abuse;
- A felony conviction related to a controlled substance occurring after August 21, 1996.

Name_____Signature_____

Date_____

http://oig.hhs.gov/exclusions/index.asp

Results of OIG Federal Inquiry:

Circle One: No Match Found Organization or Business Owner Manager

Name of individual/entity which resulted in an exclusion match_____

Exclusion Code_____

Transportation Coordinator/Designee Signature_____

Date_____

https://providertracking.dhhs.state.nc.us/default.aspx

Results of NC DHHS Provider Penalty Tracking Database

Circle One: No Match Found SSN Owner

Name of owner and/or SSN of owner which resulted in an exclusion match_____

Exclusion Reason (Action Issued)_____

Transportation Coordinator/Designee Signature_____

Date_____