

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: Please 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 _____