

# 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 no one affiliated or employed with \_\_\_\_\_ has ever been convicted of:

- Medicare/Medicaid or any other healthcare program fraud;
- Neglect or abuse of a client;
- Fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;
- Interference or obstruction of an investigation into any of the above criminal offenses.

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 \_\_\_\_\_