PROVIDER TYPE PROFILE

PROVIDER TYPE	28	NON-EMERGENCY TRANSPORTATION PROVIDERS
REIMBURSE-MENT TYPE	02	FEE FOR SERVICE EFFECTIVE 10/01/1982

CATEGORIES OF SERVICE			LICENSE/CERTIFICATION
MANDATORY	31	NON-EMERGENCY TRANSPORTATION	PROOF OF VEHICLE INSURANCE COPY OF ONLINE TRAINING CERTIFICATE COPY OF REGISTRATION FOR EACH VEHICLE REQUIRED COMPANY'S NAME AND LOGO MUST BE ON ALL VEHICLES COPY OF CPR AND FIRST AID CARD FOR EACH DRIVER COMPLETED DRIVER INFORMATION PROFILE HIPPA TRAINING ANNUALLY, PROOF WILL BE VERIFIED ON SITE VISIT SERVICES PROVIDED ON RESERVATION MUST SUBMIT COPY OF TRIBAL BUSINESS LICENSE TAXI COMPANIES MUST SUBMIT A COPY OF THEIR LICENSE FROM THE DEPARTMENT OF WEIGHTS AND MEASURES.

As the Owner/Provider you are responsible for maintaining and providing upon request a valid Arizona drivers license for each driver and proof of insurance, CPR and First Aid cards, & HIPPA training documents.

As part of the registration process the Owner/Provider is required to disclose each employee's name, employment begin date, employment end date (if applicable), date of birth, and social security number information using the 2nd page of this form.

Any changes to the above must be reported within 30 days.

By signing below you are indicating that this information will be kept on file and made available upon request.

Company Name_____ ID Number:_____

Signature_____ Date_____

SPECIAL INSTRUCTIONS: ALL NON-EMERGENCY TRANSPORTATION SERVICES GREATER THAN 100 MILES REQUIRE PRIOR AUTHORIZATION. FOR PRIOR AUTHORIZATION OF FFS CLAIMS, CALL 1-800-433-0425.

REVISED 1/9/2015

NON EMERGENCY DRIVER INFORMATION

PROVIDER TYPE	28	NON-EMERGENCY TRANSPORTATION *(Page 2 of 2) **COMPANIES ONLY**
REIMBURSE-MENT TYPE	02	FEE FOR SERVICE EFFECTIVE 10/01/1982

List of Employees

(ALL FIELDS ARE MANDATORY)

Last Name:	First Name, Middle Initial:	SSN:
Employment Begin Date:	Employment End Date:	Date of Birth: (MM/DD/YYYY)
Last Name:	First Name, Middle Initial:	SSN:
Employment Begin Date:	Employment End Date:	Date of Birth: (MM/DD/YYYY)
Last Name:	First Name, Middle Initial:	SSN:
Employment Begin Date:	Employment End Date:	Date of Birth: (MM/DD/YYYY)
Last Name:	First Name, Middle Initial:	SSN:
Employment Begin Date:	Employment End Date:	Date of Birth: (MM/DD/YYYY)
Last Name:	First Name, Middle Initial:	SSN:
Employment Begin Date:	Employment End Date:	Date of Birth: (MM/DD/YYYY)

Copy if additional pages are needed. REVISED 1/9/2015

This information is required in accordance with 42 CFR 455 Subparts B and E and State Medicaid Director Letters 08-003 & 09-001.

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