



PROVIDER TYPE SPECIFIC CHECKLIST PACKET FOR THE LOUISIANA MEDICAL ASSISTANCE PROGRAM

(Louisiana Medicaid Program)

Non-Emergency Medical Transportation

STOP!!!

If an owner or a co-owner has been convicted of any of the criminal offenses listed below, you must contact the Program Integrity Special Investigations Unit at (225) 219-4149 before going any further:

Medicaid, Medicare, any other healthcare program fraud;

Neglect or abuse of a patient;

Unlawful manufacture, distribution, prescription or dispensing of a controlled substance;

Fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;

Sexual acts;

Interference or obstruction of an investigation into any of the above criminal offenses

PLEASE READ THIS LETTER VERY CAREFULLY!



State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing

May 21, 2009

MEMORANDUM

To: Licensing Applicants

From: Erin Rabalais, Manager
Health Standards Section

Re: Initial Licensing Surveys

The Health Standards Section (HSS) is contracted with the Centers for Medicare and Medicaid Services (CMS) to conduct certification and complaint surveys of those providers already enrolled in Medicare. In accordance with this contract, HSS must complete the required workload within the time requirements specified by CMS. Please note that in order to accomplish the mandated workload, surveys are prioritized. At this time complaint surveys, recertification surveys and standard surveys of existing providers are assigned a higher workload priority than initial licensing surveys.

Therefore, as a prospective licensing applicant you should be aware that there may be delays in the scheduling of your initial licensing survey.

500 Laurel Street • Suite 100 (70801-1811) • P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-5292 • WWW.DHH.LA.GOV
“An Equal Opportunity Employer”



Dear Prospective NEMT Provider:

We thank you for your interest in becoming a Medicaid NEMT provider.

Attached you will find the forms specifically related to the Non-Emergency, Non-Ambulance Medical Transportation Program.

All providers must be certified to participate in the Medicaid Program. This requires that you correctly complete all forms from this packet and the Basic Enrollment Packet. You must also successfully pass an inspection in accordance with state regulations. Please note that some forms must be notarized.

Before completing your application forms, you should contact the Health Standards NEMT Program Desk at 225-342-9404 to verify that your business name is not already in use by another provider or prospective provider.

Prior to completing and submitting the enclosed forms, you must do the following things:

- Obtain an IRS Taxpayer Identification Number in your business name.
- Open a checking account in the name of your proposed transportation business entity.
- Obtain a suitable vehicle (no pick up trucks or two door sports cars).
- Complete a MT-10 Form (enclosed) and submit it to the Louisiana Public Service Commission.
- Register the vehicle with the Louisiana Department of Public Safety, Office of Motor Vehicles. You must register the vehicle in your business name and you must purchase a "For Hire" license plate.
- Have each prospective driver obtain a Louisiana Chauffeurs' License (Class D or higher) from the Office of Motor Vehicles. While the driver is obtaining his or her chauffeurs' license, have them obtain a copy of their online driver record.
- Obtain the required Criminal Background Check from the Louisiana State Police, Bureau of Criminal Identification for any and all drivers you intend to hire. The Department will need written proof that you have submitted these requests. The easiest way to do this is to submit a copy of the request for the criminal history along with a copy of the check or money order used to pay for it.
- Have each prospective driver successfully complete a National Safety Council approved Defensive driving course.
- Purchase both commercial automobile liability and commercial general liability insurance that meets the Department's requirements. Have the agent send the Department both the Certificate of Insurance and a letter stating that your insurance has been paid in advance for 90 days. The Department does not accept insurance binders or Louisiana Insurance Identification Cards.
- Publish your "Notice of Intent to do Business" in the appropriate local newspapers. Submit a copy of the notice from the paper to submit to the Department.

- If you are operating your business in Jefferson, and Orleans Parishes, and the City of Shreveport you must apply for and, be granted the appropriate non-emergency medical transportation permit.

Once you have completed all of the necessary forms (this packet and the Basic Enrollment Packet), have the necessary forms notarized, and add the required documentation, please mail everything to the following address:

DHH Health Standards
NEMT Program Desk
Post Office Box 3767
Baton Rouge, Louisiana 70821

Once the NEMT Program Desk receives your packet it takes at least two weeks to process your packet. If anything is missing or incorrect, the application will be returned to you. **Every time a packet is returned to you it delays your enrollment into the program by at least two weeks.**

Once you have completed all of the requirements and your application has been approved, it will be sent to one of the Health Standards Field Offices in either New Orleans, Mandeville, or Shreveport (whichever one is closest to your location) to be assigned to a surveyor for an initial inspection. The Field Office will contact you directly and make an appointment.

After your inspection has been successfully completed, your results will be faxed back to the Health Standards NEMT Program Desk. Once it is reviewed and approved by the NEMT Program Manager, your application will be forwarded to the Provider Enrollment Unit at Molina Medicaid Solutions. There it will be assigned a provider number. Once processing is completed at Molina Medicaid Solutions, they will notify First Transit to begin giving you trip authorizations. Molina Medicaid Solutions will notify you of your provider number via letter and send you a provider manual. This should be within four weeks of your inspection.

We have also enclosed the necessary forms that you will need to add or change vehicles or drivers once you are in the program. We highly recommend that you keep clean copies of the NEMT Driver Form (HSS-MT-8), NEMT Driver Change Form (HSS MT-8C), NEMT Vehicle Inspection Form (HSS-MT-9), and the NEMT Request for Inspection Form (HSS-MT-15), and its instructions.

Thank you for your cooperation.

Sincerely,

Health Standards NEMT Program Desk

INSTRUCTIONS FOR COMPLETING NEMT REQUEST FOR INSPECTION (FLEET ADDITION) FORM (HSS-MT-15)

This form is to be used to add vehicles to your fleet. All additions to your fleet, whether permanent or temporary must be reported to the Department and permitted for use prior to the vehicle being used to transport Medicaid clients. Please keep copies of this form and these instructions in your files at all times. Feel free to copy the form as needed.

Fill in all blanks on the form with the appropriate information, and attach the following documents:

1. The Certificate of Registration from the Louisiana Office of Motor Vehicles
2. A copy of your current insurance certificate showing the Vehicle Identification Number of the new vehicle added to your policy. Your insurance agent must follow this up with an original Certificate of Insurance showing that the new vehicle has been added to your policy.

We do not accept Louisiana Automobile Insurance Identification cards.

3. A NEMT Vehicle Inspection Form (HSS-MT-9A) with section 1 completed.

(Note: this list of required attachments is also on the fleet addition form.)

Fax this form and the required attachments to the Health Standards NEMT Program Desk at 225-342-0157. All documents are to be faxed to this office at the same time. Keep the originals and give them to the surveyor when he or she inspects your vehicle.

A temporary permit will be faxed to you within two working days receipt of your vehicle Information. Complete this permit, sign it, and fax it to this office at the telephone number listed above. I will review the information, sign the permit, and fax it back to you. You may now use the vehicle until it is inspected. Keep a copy of the permit in the vehicle at all times.

Please note: A copy of the Louisiana Public Service Commission Form MT-10 (Affidavit) has been included. If you do not have a "For Hire" waiver from the Louisiana Public Service Commission, you will need to complete this form and submit it to them for approval. Once you receive the waiver back from them, you must submit it to the Office of Motor Vehicles in order to obtain your "For Hire" license plate.

If you need additional information, you may contact the NEMT Program Desk at 225-342-9404.

NEMT REQUEST FOR INSPECTION (Fleet Addition)

TO: HEALTH STANDARDS NEMT PROGRAM DESK
via fax @ 225-342-5292; or mail to ;
Post Office Box 3767
Baton Rouge, Louisiana 70821-3767

COMPLETE ALL NECESSARY BLANKS:

Date of Request: ____/____/____ Unit Number: ____

Provider Name: _____ Provider Number: _____

Provider Address: _____

City, State, Zip: _____

Telephone: _____ Fax Number: _____

Contact Person: _____

Reason for Inspection:

____ Additional Vehicle VIN: _____

____ Replacement Vehicle VIN: _____

Replacing Unit Number: ____ VIN: _____

____ Windshield Replacement ____ Other

This vehicle will be ready for inspection on (date): _____

This form must be accompanied by the:

1. Certificate of Registration indicating that it has the appropriate license plate (hire, taxi, hire bus, or public)
2. Certificate of Insurance listing the vehicle by physical description and VIN indicating the vehicle has been placed on your NEMT fleet automobile liability policy.
3. A MT-9 form with Section I completed.
4. The appropriate municipal permit if applicable (Jefferson and Orleans Parishes, and the City of Shreveport)

Your Health Standards Regional Office will contact you and schedule an inspection.

Non-Emergency Medical Transportation CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that are required in order to enroll in the Louisiana Medicaid Program as an NEMT provider:

Completed	Document Name
<input type="checkbox"/>	* 1. Completed Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
<input type="checkbox"/>	* 2. Completed PE-50 Addendum – Provider Agreement Form (two pages).
<input type="checkbox"/>	* 3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.
<input type="checkbox"/>	* 4. Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business. (Only the Disclosure of Ownership portion of this enrollment packet can be done by choosing Option 1.) Option 1 (preferred): Provider Ownership Enrollment Web Application. Go to www.lamedicaid.com and click on the Provider Enrollment link on the left sidebar. After entering ownership information online, the user is prompted to print the Summary Report; the authorized agent must sign page 3 of the Summary Report and include both pages 2 and 3 with the other documents in this checklist. <p style="text-align: center;">-or-</p> Option 2 (not recommended): If you choose not to use the Provider Ownership Enrollment web application, then submit the hardcopy Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business.
<input type="checkbox"/>	* 5. (If submitting claims electronically) Completed Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form and Power of Attorney Form (if applicable).
<input type="checkbox"/>	6. Copy of voided check or letter from the bank on bank letterhead verifying the account and routing number for the account to which you wish to have your funds electronically deposited (deposit slips are not accepted).
<input type="checkbox"/>	7. Copy of a pre-printed document received from the IRS showing both the employer identification number (EIN) and the official name as recorded on IRS records (W-9 forms are not accepted).
<input type="checkbox"/>	8. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 45 (Profit) or Code 46 (Non-profit). Please note: Providers cannot be classified as non-profit until proof from the IRS is submitted to Molina Medicaid Solutions Provider Enrollment.
<input type="checkbox"/>	** 9. Non-Emergency Medical Transportation (NEMT) License Application Form.
<input type="checkbox"/>	** 10. Notarized Hold Harmless Agreement.
<input type="checkbox"/>	** 11. Driver's Form (MT-8) <ul style="list-style-type: none"> <input type="checkbox"/> Copy of Driver's License (either a valid Chauffeur or Commercial) <input type="checkbox"/> Copy of Defensive Driving Certificate <input type="checkbox"/> Copy of Online Driving Record (ODR) Report (available through the Office of Motor Vehicles) <input type="checkbox"/> Criminal background checks for all drivers (from the Louisiana State Police or their authorized vendor)
<input type="checkbox"/>	** 12. Vehicle Inspection Form (MT-9) for each vehicle with Section A completed, and <input type="checkbox"/> Copy of Certificate of Registration for each vehicle.
<input type="checkbox"/>	13. Copy of the "For Hire" waiver affidavit received after submitting the completed MT-10 (**) form to the Louisiana Public Service Commission.
<input type="checkbox"/>	14. Proof of Automobile Liability Insurance <ul style="list-style-type: none"> <input type="checkbox"/> Certificate of Insurance to be submitted now with this application. <input type="checkbox"/> Certified copy of the insurance policy to be mailed directly to Health Standards by the insurance company (not the agent). <p style="text-align: center;">Note: Insurance Verification Cards are NOT accepted.</p>
<input type="checkbox"/>	15. Proof of Prepayment of Automobile Liability Insurance (contact your insurer to obtain proof that the insurance is paid up 90 days in advance).
<input type="checkbox"/>	16. Proof of General Liability Insurance on the business <ul style="list-style-type: none"> <input type="checkbox"/> Certificate of Insurance to be submitted now with this application. <input type="checkbox"/> Certified copy of the insurance policy to be mailed directly to Health Standards by the insurance company (not the agent).
<input type="checkbox"/>	17. Proof of Prepayment of (business) General Liability Insurance (contact your insurer to obtain proof that the insurance is paid up 90 days in advance).
<input type="checkbox"/>	18. Notice of Intent to Do Business (copy of the newspaper announcement OR an affidavit from the newspaper confirming that the announcement was published).
<input type="checkbox"/>	19. Copy of a Municipal License (city permit, business or occupational license that is obtained from the Sheriff's Office Tax Department or the Municipality Finance Office) and if the business is located in one of the following parishes: <ul style="list-style-type: none"> <input type="checkbox"/> Orleans Parish: Also include a copy of the CPNC (Certificate of Public Need and Conveyance) obtained from the Department of Safety and Permits, Taxicab Bureau. <input type="checkbox"/> Jefferson Parish: Also include a copy of the NEMT (Non Emergency Medical Transportation) Permit from the Emergency Medical Service (EMS) Office of the East Bank Consolidated Fire Department. <input type="checkbox"/> Caddo Parish: Also include a copy of the Class B Ambulance Permit, from the City of Shreveport Chief Administrative Officer.

*These forms are available in the **Basic Enrollment Packet for Entities/Businesses**.

** These forms are included here.

PLEASE USE THIS CHECKLIST TO ENSURE THAT ALL REQUIRED ITEMS ARE SUBMITTED WITH YOUR APPLICATION FOR ENROLLMENT. ATTACHED FORMS MUST BE SUBMITTED AS ORIGINALS WITH ORIGINAL SIGNATURES (NO STAMPED SIGNATURES OR INITIALS). NO STAPLES.

Mail To: Bureau of Health Services Financing, Health Standards Section, P.O. Box 3767, Baton Rouge, LA 70821-3767, Attention: NEMT Program Desk.

NO STAPLES PLEASE!

NON-AMBULANCE NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) ENROLLMENT

Thank you for your interest in becoming a Medicaid provider. Your participation will enable the Medicaid Program to provide more services to a larger number of Medicaid recipients. As a non-ambulance, non-emergency medical transportation (NEMT) provider, you will provide medically necessary transportation to and from Medicaid-approved appointments without cost to recipients who have no other available means of transportation.

These services may be provided via automobile, vans, taxis, and commercial vehicles such as buses and aircraft. Providers will be classified as one of the following types:

- √ **Friends and Family Provider** – a friends or family member who will transport recipient(s) to appointment(s) and is enrolled in the NEMT program.
- √ **Non-Profit Providers** – business establishments operated by or otherwise affiliated with any public (parish, city, state, or federal) organization. The profits from these business establishments benefit the organization.
- √ **Profit Providers** – corporations, partnerships, or individuals who are certified by the Bureau of Health Services Financing and who benefit from the business proceeds.
- √ **Taxis** – corporations, partnerships, or individuals who have a state license to operate as a taxi and a permit from the local governing body.

NEMT providers may not subcontract. Profit providers such as nursing homes, Developmentally Disabled (DD) group or community homes, hospitals, etc. may not provide transportation for their own clients and bill Medicaid, but they may bill Medicaid if they transport other Medicaid recipients.

BASIC NEMT PROGRAM REQUIREMENTS

The Medicaid Program requires that all NEMT providers have (at minimum) auto liability coverage of \$100,000.00 per person and \$300,000.00 per accident or a combined service limit of \$300,000.00. This policy will cover any automobiles (hired automobiles and non-owned automobiles). Providers will have a minimum of \$300,000.00 of general liability insurance in the name of the business. Premiums must be pre-paid for a six-month period. Proof of insurance is a notarized, original certificate of insurance which includes the dates of coverage and a 30-day cancellation notification clause. This certificate must be issued to the Bureau of Health Services Financing.

All vehicles used in the NEMT program must be inspected and approved. The vehicles must be properly licensed (“for hire” plates are required on all vehicles except those with “public” license plates). They must have a current state inspection sticker, seat belts, operational air conditioning and heating systems, a child restraint seat, a first aid kit, a PPE kit, a fire extinguisher on board, be safe to operate, and be compliant with pertinent portions of Title 32 of the Louisiana Revised Statutes (Highway Regulatory Act). All vehicles and their required systems such as air conditioning must function in accordance with manufacturers standards.

Providers must comply with all state laws and the regulations of any other governing state agency, commission, or local entity to which they are subject as a condition of enrollment and continued participation in the Medicaid Program.

Profit and Non-Profit providers must have either a fax machine or the Blast software capability as determined by the Medicaid Program based on the volume of trips authorized to the provider.

Providers must comply with all applicable federal interstate commerce laws regarding transportation including, but not limited to, the \$1,000,000.00 insurance requirement.

Providers must agree to serve the entire parish or parishes for which he/she provides transportation. (Exception : Providers in Jefferson and Orleans Parishes may choose to serve only the East or the West Bank of the parish.)

Providers are required to immediately report to their area inspector any changes which affect their participation such as fleet size or reduction in the number of parishes covered.

TRANSPORTATION SCHEDULING SERVICES

Medicaid will reimburse providers only for approved medical transportation for eligible Medicaid recipients. Additionally, Medicaid recipients will be screened by the transportation dispatch office to determine the need for transportation and the availability of the least costly means of transportation.

Recipients are required to contact their area dispatch office in 48 hours advance to schedule appointments. Same-day trips will not be authorized except for certain types of medical necessity. All family members needing to go to the doctor should go on the same day at or about the same time to avoid the need for more than one trip per day. Some recipients may be asked to reschedule appointments to accomplish this. Trips will be scheduled using the following hierarchy: city or public transportation (such as buses), friends and family providers, non-profit providers, and then profit providers.

NOTE: Transportation providers cannot call dispatch on behalf of the recipient to schedule an appointment. The only medical facilities authorized to fax requests to schedule appointments on behalf of their patients are hemodialysis facilities, long-term care facilities(nursing homes), and KIDMED facilities.

Denial for Prior Authorization and New Specialized NEMT Codes (Memorandum from Thomas D. Collins – November 1, 1994)

Denial for Prior Authorization

After the implementation of the automated prior authorization system, a number of providers experienced problems when billing for NEMT services. These denials and the corrective actions to be taken are as follows:

“190-Prior Authorization Not on File” – There is no Prior Authorization number on file at Molina Medicaid Solutions for the recipient for the date of service. In some instances, authorization numbers fail transmission to Molina Medicaid Solutions and do not appear unless Dispatch verifies that an authorization was sent. The claim must be resubmitted once the authorization is submitted by Dispatch and is on file at Molina Medicaid Solutions.

“191-Requires Prior Authorization” – There is no match with the authorization number on file at Molina Medicaid Solutions. Many “191” denials stem primarily from instances where the Dispatch Office sends Molina Medicaid Solutions authorization for one procedure code and the provider submits a claim with a different procedure code. For example, a provider agrees to a reduced rate bills the trip as “Z5178” as a negotiated trip, but it should be billed as a “Z5177”-Local Trip even though it is at a reduced rate. A new denial code (“198-Prior Authorization Procedure Not Same as Claim Procedure”) will assist in differentiating when the denial is due to the procedure codes on the claim and the prior authorization file not matching. Please note that when a provider has agreed to a reduced rate for a local or capitated trip, the appropriate code for local (Z5177 or Z9498) or capitated trip (Z5179 or Z5180) should be billed, not a “negotiated” trip (Z5178). Negotiated trips should be billed only when the trip is outside the “local area.” Please check the billing programs to ensure that the appropriate codes are being used in billing Medicaid. Dispatch must also use the appropriate codes when authorizing trips. If the wrong procedure code is used in the authorization sent to Molina Medicaid Solutions, it must be cancelled and resent by the Dispatch office. “191” denials can also occur if your authorization number is not in the correct place on the claim form. Please check your programming and ensure that the authorization number is appearing in Item 11. Claims previously denied for this error should be corrected as appropriate and resubmitted to Molina Medicaid Solutions.

“192 – Prior Authorization Has Not Been Approved” – A request for prior authorization was not approved. This claim cannot be paid and should not be resubmitted.

“193 – Date on Claim Not Covered By Prior Authorization” – The date of service on the claim does not have an authorization number even though there may be an authorization number on file for a different date of service for that recipient. If a trip is not made and is made at a later date, it is not acceptable to use the same authorization. Rather, the original number must be cancelled and a new authorization number issued by the Dispatch Office. Once the new authorization number for that date of service is on the file, you may resubmit your claim for payment.

“194- Claim Exceeds Prior Authorization Limits” – The authorization number for that recipient for that date of service has already been used to pay for a claim for that trip. You must contact Dispatch to determine if there was an error and an authorization number was used twice; and if appropriate, have a new authorization number sent to Molina Medicaid Solutions.

“196 – Claim Recipient ID Does Not Match ID on the Prior Authorization File” – The claim was denied because the recipient number on the claim does not match the recipient number on the Prior Authorization File at Molina Medicaid Solutions. Please ensure that the correct recipient number was used in billing and also that the Dispatch Office used the correct ID in authorizing the trip. Another recipient’s authorization number cannot be used for a different recipient even if they are in the same family. An authorization number for each individual must be obtained if several family members are being transported on the same date of service.

“197- PA Provider ID Not Same as Claim Provider ID” – The provider number sent by Dispatch to Molina Medicaid Solutions’ Prior Authorization file was not the same as that on the claim submitted for that recipient for that date of service. There has been a problem with Dispatch offices using an

in-house provider number or an outdated provider number rather than the current provider number on file at Molina Medicaid Solutions. This results in "197" denials. Please ensure that Dispatch has the correct current provider number. If the incorrect number was used, Dispatch will need to send Molina Medicaid Solutions a new authorization. Once the authorization is resubmitted, the claim should be resubmitted to Molina Medicaid Solutions.

In the future, the Dispatch office will forward to Molina Medicaid Solutions' Prior Authorization file, the following information: recipient name, Medicaid identification number, date of service, procedure code for type of trip, authorization number and amount authorized. The claims processing system will require a match on all of these items to successfully process the claim. Claims that do not match all items will be denied. The Dispatch Offices are being advised of these same findings and asked to correct any errors in the codes or provider numbers they are authorizing.

Claims that were denied should be resubmitted with any necessary corrections. If there are any further problems, please contact your Molina Medicaid Solutions Provider Relations representative to arrange a visit where appropriate corrective actions can be explained.

New Specialized NEMT Codes Effective for Dates of Service 11/1/94 and After

The Department has established several additional specialized transportation service codes and rates effective for dates of service November 1, 1994 and after. These are noted below:

- Z5182 – Enhanced Capitated Monthly Rate** – for patient whose capitated trips (for medical services which are regular, predictable and continuing) require more than 5 trips per week (including wheel-chair bound patients who are non-ambulatory). Payment is a monthly rate of \$300.00
- Z5183 – Capitated – Remote Rural Monthly Rate** – for patient whose capitated trips for necessary medical services are greater than 120 miles round trip (including wheel-chair bound patients who are non-ambulatory). Payment is a monthly rate of \$300.00
- Z5184 – Capitated – Wheelchair – Rural** – for patient in rural area who is wheelchair-bound and non-ambulatory and whose trips are capitated on a monthly basis. Payment is a monthly rate of \$250.00
- Z5185 – Capitated Wheelchair – Urban** – for patient in urban area who is wheelchair-bound and non-ambulatory and whose trips are capitated on a monthly basis. Payment is a monthly rate of \$180.00.
- Z5186 – Local Trip – Profit – Wheelchair** – local trip for a patient who is wheelchair-bound and non-ambulatory. Payment is \$25.00 per round trip.
- Z5187 – Local Trip – Nonprofit – Wheelchair** – local trip for a patient who is wheelchair – bound and non-ambulatory. Payment is \$20.00 per round trip.

Please ensure that necessary programming changes to the billing procedures are completed if needed to reflect these codes. The Dispatch Offices were notified of these new codes at the same time this notice was mailed to providers. The Dispatch Office shall authorize these codes when appropriate. Rates for negotiated trips (Z5178, Z5176, and Z5181) shall take into consideration when the patient is wheelchair-bound and non-ambulatory.

Please note also that the Department is now maintaining complaint files on all NEMT providers regarding failure to pick up recipients in a timely manner before or after medical appointments or arriving too late for appointments. At annual vehicle inspections, the volume of complaints for that provider shall be reviewed and a determination made regarding the provider's continued participation in the program if complaint volume indicates repeated problems with adhering to the NEMT program's regulations (Federal and State). In the event participation in the Program is affected based upon the volume of valid complaints, the Bureau will adhere to existing procedures for due process.

Please contact Molina Medicaid Solutions Provider Relations (225) 924-5040 or the Transportation Program (225) 342-9404 if you have any questions.



STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



NON-EMERGENCY MEDICAL TRANSPORTATION
LICENSE APPLICATION FORM

check if any change has occurred since last application

I. PROVIDER (DBA) NAME _____
GEOGRAPHICAL ADDRESS _____
CITY / STATE / ZIP _____
TELEPHONE NUMBER (____) _____ FAX NUMBER (____) _____ EMAIL ADDRESS _____

II. MAILING ADDRESS (IF DIFFERENT FROM ABOVE) _____
CITY / STATE / ZIP _____

III. OWNER'S NAME _____
MAILING ADDRESS (IF DIFFERENT FROM ABOVE) _____
CITY/STATE/ZIP _____

IV. TYPE OF OWNERSHIP: SOLE OWNER PARTNERSHIP CORPORATION GOVERNMENT

V. List name, address, and telephone numbers for persons or group of persons having direct or indirect ownership or a controlling interest (.5%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity (ATTACH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).

OWNER	ADDRESS	TELEPHONE #

VI. HOLD HARMLESS AGREEMENT: All applicants must execute a Hold Harmless Agreement in favor of the state. The agreement must be notarized. The Hold Harmless Agreement providers must use is provided in the packet.

VII. DRIVER REQUIREMENTS: Total Number of Drivers Employed: _____
Every driver must complete a Driver Enrollment Form (MT 8), which must be submitted to the Department prior to driving in the program. The MT 8 form is included in this packet.

In addition to the MT 8 Form, you must also include with your application:

1. A copy of his or her chauffeur's license
2. Written verification of successful completion of the appropriate Defensive Driving Course
3. A copy of his or her on-line driver record from the Office of Motor Vehicles

NOTE: All drivers of vehicles enrolled in the NEMT program must:

1. Be 25 years of age or older
2. Hold a valid chauffeur's or commercial driver's license (Louisiana class A, B, C, or D or the equivalent in the driver's state of residence)
3. Successfully complete a defensive driving course recognized by the National Safety Council or its equivalent as determined by the Department

NON-EMERGENCY MEDICAL TRANSPORTATION LICENSE APPLICATION FORM

VIII. SERVICE AREA REQUIREMENTS:

The provider service area is defined as the parish or parishes in which the provider had either a main office or a substation. A parish can only be a service area for a provider if he has an office located in the parish and at least one vehicle based there. A provider must accept all trip authorizations within the parish or parishes and all reasonable proximity trips to adjacent parishes. List the parish or parishes that you wish to operate, the number of vehicles to be used in each parish, and the location of the office in each parish.

NOTE: The East Bank and the West Bank of Jefferson parish are counted as two separate parishes. You may serve one or the other or both.

<i>PARISH</i>	<i>NUMBER OF VEHICLES</i>	<i>OFFICE LOCATIONS</i>

IX. VEHICLE REQUIREMENTS:

A participating provider must own or lease all vehicles that will be used to provide NEMT program transportation services. Proof must be submitted indicating that each vehicle(s) is/are registered in the transportation service's name. If the vehicle is under lease, the period of the lease must run concurrently as the inspection period. **TRANSPORTATION PROVIDERS MAY NOT SUBCONTRACT.**

All information pertaining to the lease or ownership of each vehicle must be listed in the appropriate space on the NEMT Vehicle Inspection Form (MT 9 A & B). The provider is to complete Section I of the MT 9 form for each vehicle participating in the NEMT program and return it with a copy of the vehicle's Certificate of Registration from the Office of Motor Vehicles.

All vehicle certification requirements are listed on the MT 9 form. Every vehicle participating in the program must be inspected and certified to participate in the program every year.

Cars must have "Hire Taxi" license plates and vans must have "Hire Bus" license plates.

At the time of enrollment, the provider must stipulate whether each vehicle will be used for services to ambulatory or non-ambulatory recipients.

X. VEHICLE INSURANCE:

Providers are required to have minimum automobile liability coverage insurance limits of \$100,000 per person and \$300,000 per accident or a \$300,000 combined single limit policy. The policy shall cover Any Automobiles (schedule 1); or owned, hired, leased and non-owned automobiles (schedules 2 or 4; and 8 and 9). Scheduled automobile policies (Schedule 7) are not permitted.

The insurance company's home office must send the Department a true and correct copy of the insurance policy to verify coverage. The insurance must be prepaid for at least the next three month period. The insurance company must also verify in writing that the policy is prepaid for the next three months.

Providers who intend to transport out-of-state medical appointments must carry \$1,000,000 automobile liability insurance in addition to comply with all federal interstate commerce laws pertaining to such transportation. For more information, contact the Public Service Commission.

The Department must be listed as the "Certificate Holder" for all automobile and general liability insurance carried by NEMT providers. This should read as follows on all policies and certificates:

Bureau of Health Services Financing
Health Standards Section
Post Office Box 3767
Baton Rouge, Louisiana 70821-3767
Attention: NEMT Program Desk

NON-EMERGENCY MEDICAL TRANSPORTATION LICENSE APPLICATION FORM

The policy must have a cancellation/change statement requiring notification of the certificate holder 30 days prior to any cancellation or change of coverage.

The “true and correct copy” of the insurance policy must be mailed directly to Health Standards by the insurance company (not the agent). All policies and certificates must indicate that they cover non-emergency medical transportation vehicles and have an original signature of the insurance company’s authorized representatives.

Once the vehicles are inspected and certified for participation in the NEMT program, each vehicle will have a decal placed on it by the surveyor. In addition to initial and periodic recertification inspections, the Department may conduct spot inspections at any time and any location within the state. Any vehicle failing a spot inspection will have its decal removed. The vehicle will have to be inspected again before it can be used again to transport Medicaid clients.

XI. GENERAL LIABILITY INSURANCE REQUIREMENTS:

Each Medicaid transportation provider must be covered by general liability insurance on the business, with a minimum coverage of \$300,000 combined single limit liability. A “true and correct” copy of the policy must be submitted as part of the enrollment packet indicating the amount of coverage, dates of coverage, etc. This policy must also show BHSF as the certificate holder (see above). Insurance must be prepaid for a three month period. The insurance company must also verify in writing that the policy is prepaid for the next three months.

The policy must have a cancellation/change statement requiring notification of the certificate holder 30 days prior to any cancellation or change of coverage.

XII. LOCAL LICENSE & PERMIT REQUIREMENTS:

If the provider’s city or parish requires a special license and/or permit to operate a medical transportation service, providers must attach a copy of the current license or permit to this form before mailing it to Health Standards. These ordinances exist in Orleans and Jefferson Parishes and the City of Shreveport.

ATTESTATION:

It is my responsibility to notify the Department of Health and Hospitals, Bureau of Health Services Financing, Health Standards Section in writing of any changes in the information provided in this application. I certify that the information herein is true, correct and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Department of Health and Hospitals.

(NOTE: If Sole Ownership – the owner must sign; If a Partnership - all partners must sign; If a Corporation or Government Entity – the Chief Executive Officer (president, mayor, CEO) and the authorized representative must sign.

_____/_____/_____/_____/_____
 AUTHORIZED REPRESENTATIVE NAME & TITLE (TYPED OR PRINTED)/ AUTHORIZED REPRESENTATIVE’S SIGNATURE / DATE SIGNED

_____/_____/_____/_____/_____
 AUTHORIZED REPRESENTATIVE NAME & TITLE (TYPED OR PRINTED)/ AUTHORIZED REPRESENTATIVE’S SIGNATURE / DATE SIGNED

_____/_____/_____/_____/_____
 AUTHORIZED REPRESENTATIVE NAME & TITLE (TYPED OR PRINTED)/ AUTHORIZED REPRESENTATIVE’S SIGNATURE / DATE SIGNED

_____/_____/_____/_____/_____
 AUTHORIZED REPRESENTATIVE NAME & TITLE (TYPED OR PRINTED)/ AUTHORIZED REPRESENTATIVE’S SIGNATURE / DATE SIGNED

HOLD HARMLESS AGREEMENT

_____, a medical transportation provider enrolled in the Medicaid Program and providing transportation services for Medicaid recipients, agrees to indemnify, defend, and hold harmless the Department of Health and Hospitals, Bureau of Health Services Financing, from any claims or liabilities whatsoever of any nature arising from the operation of a vehicle by the provider or his employees, agents, etc., and any acts of negligence or misconduct attributable to the provider of his employees, agents, etc.

Provider's Signature

Date

Witness

Witness

Notary Public

Notary Seal (required)

NOTICE OF INTENT TO DO BUSINESS

The prospective provider must publish a notice of intent to do business in the newspaper(s) which is/are circulated in his/her geographic area. This notice should appear in the local paper and regional paper at least one time. The format of the notice is provided on the following page. A copy of the notice as it appeared in the newspaper should be submitted with the enrollment documents.

NOTICE OF INTENT TO DO BUSINESS

We are applying to the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, Louisiana 70821-9030, for approval to enroll in the Medicaid Program as a non-emergency medical transportation provider in the parish(es) of _____. Our business will be located at the following address:

John Doe d/b/a Doe's Transportation Service
11234 Main Street
Baton Rouge, LA 70821

John C. Doe,
President

DRIVER INFORMATION & DRIVER CHANGE FORM

A **Driver Information Form (MT-8)** should be completed by each driver upon enrollment and each year thereafter at the annual review. A **Driver's Change Form (MT-8-C)** should be completed and submitted when a driver leaves the employ of a provider, changes the class of his/her license, or changes his/her name or address. Provided below are the instructions for completing each of the forms.

COMPLETING THE DRIVER INFORMATION FORM

Prior to completing the Driver Information Form, the provider should ensure that all of the information on the prospective driver's operator's license is current and correct. The driver must also have a current Louisiana chauffeur's license (class D). If the driver is employed by a service in a parish bordering the state line and the driver is a legal resident of the adjacent state, the driver may have his/her state of residence's equivalent to a Louisiana chauffeur's license.

The driver's present correct name and address must be reflected on the license. Any drivers needing to change the license information should report changes to the Louisiana Department of Public Safety and Corrections, Office of Motor Vehicles, and have such corrections made prior to completing the form.

Providers should ensure that they fill in the provider name and number. If the provider is in the application process, the provider should write "new" in the blank space. In addition, the provider should fill in the driver's name and address (including city, state, and zip), social security code number, operator's license number, license class, state, and expiration dates, date of birth, race, and sex from the driver's license in the appropriate blanks. The driver's home telephone number should also be entered.

In addition, the provider should check the appropriate block to indicate whether any restrictions apply, and the provider should write an explanation of any restrictions checked.

The provider should indicate whether the driver's license has ever been suspended or revoked and offer an explanation, if applicable. Also, the driver's level of experience transporting people should be explained (how long, by bus, taxi, etc.). If the driver has worked for another NEMT provider, the provider(s) should be listed.

Whether the driver has completed the National Safety Council's or approved equivalent defensive driving course should be indicated. **On-line driving courses will not be accepted.** A driver who has not completed this course will not be approved. In addition, whether a driver has been convicted of any traffic related offense by any court (including pleas of no contest) in the last 10 years should also be indicated. This includes all LA.R.S. 32 offenses (or their equivalent in other states or municipalities), DWIs (LA. R.S. 14:98), reckless operation (L.R.S. 14:99), or vehicular homicide (L.R.S. 14:32.1), vehicular injury (L.R.S. 39.1), or their equivalents.

The form must be signed and dated by the provider and the driver and the following must be attached:

- A legible photocopy of the operator's license (an enlarged copy is preferred)
- A copy of the driver's history obtained from the Louisiana Department of Public Safety and Corrections, Office of Motor Vehicles
- A copy of the Certificate of Completion for a National Safety Council or approved equivalent defensive driving course
- And additional sheets required to complete the form (all additional sheets should be headed with the driver's name, social security number, the provider's name, and the date).
- Proof that you are obtaining a criminal background check for the driver from the Louisiana State Police or one its authorized agencies (a copy of the request plus a copy of the money order paying for the request)

If any information is falsified or credential forged, then monetary sanctions may be imposed; violators will be referred to the Attorney General's Medicaid Fraud Unit for possible criminal prosecution.

DRIVER'S CHANGE FORM

This form must be submitted to the Bureau of Health Services Financing within five working days of a change. It should be signed and dated by both the provider and the driver, unless the driver was terminated with cause. All changes of the license must also be signed by the driver, and a copy of the changed license must be attached (this includes license renewals).

DRIVER INFORMATION FORM

1. Provider's Name _____ 2. Provider Number _____

3. Driver's Name _____ 4. SS# _____ - _____ - _____
Last First M.I.

5. Maiden Name (if applicable) _____ 6. Start Date ____/____/____

7. Driver's Address _____
Street City State Zip

8. Driver's Telephone # () _____ 9. Driver's Chauffeur License: a. License # _____
b. issue Date ____/____/____ c. DOB ____/____/____ d. Class _____ e. State _____
f. Expiration Date ____/____/____ g. Sex _____ h. Race _____
i. Does license have any restrictions? Y/N If yes, indicate what the restrictions are:

10. Has license ever been suspended or revoked? Y/N If yes, explain:

11. Has driver had experience transporting people commercially? Y/N
If yes, how many years? _____ With whom? _____

12. Has driver ever worked for a NEMT company? Y/N If yes, which company and how long?

13. List the date driver had National Safety Council's Defensive Driving course.
Date of course ____/____/____

14. Has driver ever been convicted of a traffic related offense in the past 10 years? Y/N
If yes, list offense(s) and date with an explanation:

15. Has driver ever been involved in any accident which involved a fatality? Y/N If yes, explain:

16. Has driver ever been on probation or sentenced to jail/prison as a result of a felony conviction or guilty plea? Y/N
If yes, attach a separate sheet giving the law enforcement authority (city police, sheriff, FBI, etc.), the offense, date of offense, place, and disposition of case.

Your signature on this form is attesting to the validity of this information.

Driver's Signature: _____

Date: ____/____/____

Provider's Signature: _____

Date: ____/____/____

INSTRUCTIONS FOR FORM MT-9

Form MT-9, the Vehicle Inspection Form, must be completed as follows:

I. The Provider must complete the following items in the first section of this form:

- Parish in which the vehicle is stationed
- Provider's name
- Provider number – if the service is new, write “new” in the space provided
- Provider's telephone number – including area code
- The registration (business) name – this name must also be on the Louisiana Certificate of registration;
- Street address of the business, including the city, state, and zip code;
- Unit number – the number that you assign to the vehicle for tracking purposes;
- VIN (vehicle identification number);
- Make of the vehicle;
- Color of the vehicle;
- Model of the vehicle; and
- License plate number and expiration date.

Note: No vehicle will be inspected without the above completed prior to the inspection.

II. Completed by the Inspector

The remainder of this form is completed by the inspector during the inspection of the vehicle. Details of this inspection can be found in Section 7 on Monitoring and Documentation of provider manual*. After completion of the form, the inspector will have the driver or transportation company representative sign and date the form. Then, the inspector will sign and date the form.

If the vehicle has passed the inspection, the inspector will write the vehicle's decal number in the appropriate space on the form.

The inspector should ensure that the form is readable and give this copy to the driver/company representative.

*Section 7, Documentation and Monitoring, of the provider manual has been included in this enrollment packet following the HSS-MT-9b form.

INSPECTION OF VEHICLE (to be completed by the inspector)

*DENOTE OPTIONAL SERVICES

VIN # _____

ITEM	PASS	FAIL	COMMENTS	REINSPECT		REINSPECT	
				PASS	FAIL	PASS	FAIL
A1 & 2 BODY & DAMAGE							
A3 PROPERLY MARKED							
A4 TIRES							
A5 LIGHTS							
A6 MIRRORS							
A7 WINDSHEILD							
A8 WIPERS/WASHERS							
A9 WINDOWS/DOORS							
B1 INTERIOR							
B2 HEATER							
B3 AIR CONDITIONER							
B4 HORN							
B5 SEAT BELTS							
B6 EXHAUST							
C1 FIRE EXTINGUISHER							
C2 FIRST AID KIT							
C3 PPE KIT							
C4 CHILD SEAT							
C5 JACK/SPARE							
D1 WHEELCHAIR LIFT M/H*							
D2 WHEELCHAIR RAMP/TOE*							
D3 WHEELCHAIR RESTRAINTS - TYPE*							
D4 TWO WAY RADIO* SYSTEM (HANDICAP V)							

COMMENTS: _____

SURVEYOR: _____

NEMT FIRST AID KIT REQUIREMENTS

The Occupational Safety and Health Administration of the United States Department of Labor has ruled that patient transportation services are subject to its jurisdiction and, therefore, mandates that all such vehicles are required to have a first aid kit on board. The first aid kit should contain, at a minimum, the following:

- Plastic Strips ¾" X 3"
- Adhesive Tape ½" X 5 yds
- Gauze Bandage 1"
- Gauze Bandage 2"
- Non-adherent Pads 2" X 3"
- Oval Eye Pads 2" X 3"
- Cold Pack
- Bagged Pair of Latex Gloves
- Butterfly Bandages Med
- Fabric Strips ¾" X 3"
- Triangular Bandage
- Ammonia Inhalants
- First Aid Cream 7/8 oz. Tube
- Antiseptic Wipes
- Scissors
- Personal Protective Equipment Kit (see below)*

NOTE: These items will be checked during inspection.

* 29 CFR 1910 OSHA mandates personal protective equipment kit for all patient transportation services. In order to be in compliance with this section, vehicles must carry a PPE protection kit that includes rubber gloves, an impervious gown or coveralls, shoe covers, a face mask and safety goggles or a fluid shield. N-95 or N-100 masks are also highly recommended.

Insert from Provider Manual - Section 7, Documentation and Monitoring

A valid motor vehicle inspection sticker issued by the state of Louisiana or one of its municipalities must be displayed.

I. Providers must verify that:

- The correct VIN is on all paperwork (match it to the vehicle);
- The registration certificate is valid and that all information is current and correct; and
- The vehicle has a valid Louisiana license plate and MVI sticker (LA or municipalities) properly displayed.

II. The inspector will inspect the exterior of the vehicle for the following:

- **Body and Damage** – No appreciable body or paint damage or missing pieces.
- **Properly Marked** – All vehicles must have the service name and telephone number displayed in 2' letters (or greater) on the driver and passenger doors. Vans must also have this marking on the back door. Lettering must be painted, shown as a decal, or otherwise permanently attached (no magnetic signs). The color of the lettering must be in contrast to the car's paint color. The unit number must be displayed in 2' numbers (or greater) on the right and left front quarter panels adjacent to the doors in the corner where the hood, door, and windshield meet. The number must also be displayed in the left lower back glass, affixed from inside the glass.
- **Tires** – Tread in accordance with RS32 – No exposed wire, bubbles, or appreciable sidewall damage.
- **Lights** – Check headlights (high and low beams), turn signals, hazard flashers, back-up lights, brake lights, and parking lights.
- **Mirrors** – Must have left-hand outside rear view mirror and inside rear view mirror and a right-hand outside rear view mirror.
- **Windshield** – Perform paper test (8 ½" X 11" sheet held horizontally steering wheel) on windshield in driver's view and ensure that there are no stars or cracks.
- **Wipers/Washers** – Ensure that wipers and washers are functioning properly.
- **Windows/Doors** – All windows and doors must function as intended by the manufacturer.

The inspector will inspect the interior of the vehicle for the following:

- **Interior Compartment** – Ensure that the interior compartment is free from tears, holes, large stains, or offensive odors. Everything in the passenger compartment must be secure. No sharp edges, points, or other hazards are allowed in the patient compartment.

The inspector will also ensure that the vehicle contains the following equipment:

- **Fire extinguisher**
- **NEMT approved first aid kit**
- **PPE kit**
- **Child Seat**
- **Jack/Spare tire**
- **Heater** – Ensure that the heater is functional and that air at the vent is warm to the touch in accordance with manufacturers' standards.

- **Air Conditioner** – Ensure that the air conditioner is functional and that air at the vent is cool to the touch, in accordance with manufacturers' standards.
- **Horn** – Ensure that the horn functions properly
- **Seat Belts** – Functional and undamaged for all seats

The requirements for the first aid kit and PPE kit are provided on the checklist after the inspection form. Providers should ensure that each vehicle contains a minimum 2 B: C fully charged fire extinguishers within the driver's reach in the passenger compartment. All of these items must be marked with the unit number. Halon extinguishers are not permitted.

The inspector will also ensure that the vehicle contains a secured jack capable of raising a tire from the ground and an inflatable spare, in accordance with the previously mentioned tire standards.

The inspector will ensure that wheelchair vans contain the additional operating requirements listed below:

- **Lift, Manual or Hydraulic (either acceptable)** – Check for leaks, ease of operation, and panel markings (up and down). Check electrical cords for frayed or torn wiring and proper connections. Check for proper up and down operation.
- **Ramp with Toe Cleats 28" Wide** – Assure proper size
- **Wheelchair Restraints** – May use lock, well, and tiedown system or ratchet system. Either system must be bolted to the bottom of the vehicle, in accordance with the manufacturer's recommendation. If locks are used, they must have pins, and both rear wheels of the wheelchair must be secure..
- **Two – way Radio Systems** – Ensure that the two-way radio system is in working order.

The inspector will complete the bottom of the form as follows:

- Write his/her narrative based on items needed. A supplemental form should be attached, if necessary.
- Check whether the inspection is classified as an enrollment, fleet addition, recertification, or spot check inspection.
- Check whether the vehicle has passed or failed the inspection.
- Have the driver or company representative sign and date the form.
- Sign and date the form.
- If the unit passes inspection, the inspector will write the vehicle's decal number in the appropriate space.
- Ensure that the writing is readable on the form and give a copy to the driver/provider.

PROCEDURES TO OBTAIN FOR HIRE PLATES

The Department of Public Safety began requiring all Non-Emergency, Non-Ambulance Medical Transportation vehicles to have a "For Hire" license effective July 1, 1993. To obtain this license plate, the provider must:

1. Complete the attached affidavit (MT-10).
2. Have the MT-10 notarized and mail or return it to:

**Public Service Commission
P.O. Box 91154
Baton Rouge, LA 70821**

3. Upon receipt of the license approval certificate from the Office of Public Service Commission, make copies of the originals and keep them for future use.

A copy of the license certificate is to be presented to the Department of Motor Vehicles to obtain your "For Hire" license plate. One copy of the license certificate is required for each vehicle. This certificate is to be used exclusively for commercial Non-Emergency Medical Transportation vehicles only.

"For Hire" plates are to be obtained after you have been assigned a provider number. A regional transportation inspector will contact you with the provider number and advise you to obtain the "For Hire" plates at that time.

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF _____

Before me, the undersigned authority, this date personally came and appeared

_____ of _____ who, after first

Being by me _____

Duly sworn, deposes and says:

That he is engaged in the business of transporting by motor vehicle PASSENGERS

For compensation, but that he is exempt from the provisions of act 301 of Louisiana Legislature of 1938 as amended by Act 20 of Louisiana Legislature of 1946 for the following reasons:

Both provider (carrier) owned and leased vehicles will be used exclusively for commercial non-emergency medical transportation only pursuant to LRS 45:172 a. (3). The license approval certificates supplied to me by the Louisiana Public Service Commission will be used to purchase license plates for this purpose only. All license plates are to be purchased/issued in the provider's name.

SIGNATURE OF AFFIANT

Address: _____

WITNESS

Phone ()

Date: _____

Subscribed in my presence and sworn to before me by the affiant above-named this

_____ day of _____, 19__.

Notary Seal

