



TRANSPORTATION PROVIDER INFORMATION FORM

Please complete in full - Incomplete forms will be returned.

Please print or type all information. If the question does not apply, enter N/A.

Name of Organization with DBA:	
Federal Tax ID#:	NPI or UMPI:
Website:	Directory Email:

*This will be listed in the **Provider Directory***

Is your facility enrolled with Minnesota Health Care Programs (MHCP)? Yes No Enroll with Minnesota Health Care Programs / Minnesota Department of Human Services (mn.gov)
Is your organization enrolled as a Medicaid Provider with the State of Minnesota? Yes No
Is your organization Medicare (CMS) Certified? Yes No
Do your drivers speak multiple languages fluently? Yes No <i>If Yes, which languages:</i>
Do you provide an interpreter service? <input type="checkbox"/> Yes <input type="checkbox"/> No Interpreter Service used:
 Will some or all your drivers accept rides with a certified service animal? <input type="checkbox"/> Yes <input type="checkbox"/> No
 Will some or all your drivers accept rides with an emotional support animal? <input type="checkbox"/> Yes <input type="checkbox"/> No

Provide the following information for responsible contacts. Please put N/A if not applicable.

Person Responsible for/Title:	Name	Telephone	Email Address
Contracting			
Director / Owner			
Business/Billing Office			
CFO / Controller			

Primary Address:	County:
City:	State:
Phone Number:	Zip:
Publish in Provider Directory? Yes No	Fax Number:
	<i>Fax will not be listed in the Provider Directory</i>

Mailing Address:	County:
City:	State:
	Zip:

Billing Address:	County:
City:	State:
	Zip:

Payment Remit Information	Remit Name:
Address:	County:
City:	State:
Phone Number:	Zip:
	Fax Number:

Location of your Dispatch Office
Address:
City:
Phone Number:
County:
State:
Zip:
Fax Number:



Please check all that apply:

Assisted: Ambulatory w/ Walker Wheelchair Accessible Van Stretcher

Unassisted: Ambulatory (No Assistance)

Other: Please indicate what other type of transportation: _____

Operating Transit Hours

Regular Transit Hours			Extended/After Hour Transit Hours		Holiday Transit Hours		
	FROM-TO			FROM-TO		FROM-TO	
Monday	—	Closed	Monday	—	New Year's Eve	—	Closed
Tuesday	—	Closed	Tuesday	—	New Year's Day	—	Closed
Wednesday	—	Closed	Wednesday	—	Thanksgiving	—	Closed
Thursday	—	Closed	Thursday	—	Christmas Eve	—	Closed
Friday	—	Closed	Friday	—	Christmas Day	—	Closed
Saturday	—	Closed	Saturday	—	Other: <i>Please Specify below</i>	—	Closed
Sunday	—	Closed	Sunday	—		—	Closed
						—	Closed
						—	Closed

Please provide a copy of your insurance certificate.

Insurance Information

Insurance Carrier Name: _____

Policy Start Date: _____

Policy Expiration Date: _____

Policy Number: _____

Coverage Limits: _____

Carrier Address: _____

City/State/Zip Code _____

Phone Number: _____

Fax Number: _____

**Provide a list of the Counties you provide Assisted and Unassisted services.
If you only serve a portion of a county, identify which portion you service within that county.
Please indicate with an X the counties in which your drivers are located in.**

Please list all vehicles used for your transportation service, and the last MNDOT inspection date.

Vehicle Year	Make	Model	Plate #	VIN	Location of vehicle	Last Inspection Date



Driver Attestation

Please print this page for each driver to sign.

Driver Name (First MI. Last):
Company:
Driver's License Number:
NetStudy Completion Date:
<i>Per Minnesota Administrative Rules, 8840.5910 Driver and Attendant Training Requirements, before providing special transportation services, each driver and attendant must receive the following training.</i>

Required Training	Date of Most Current Completion
Operating Radio, Cellular Telephone, or other means of 2-way communication	
What to do and whom to call in a medical Emergency or Accident, including fire extinguisher and use of emergency triangles	
Conducting Daily Vehicle Inspections	
Passenger Assistance	
Instruction and demonstration in operating the vehicle ramp, wheelchair lift, and wheelchair securement devices, if the vehicle is so equipped	

*Per Minnesota Administrative Rules, 8840.5910 Driver and Attendant Training Requirements, each driver must complete the following within 45 days after beginning to provide special transportation services.
(**Drivers shall successfully complete within 3 years from the date they completed the training required in subpart2, and every 3-year period thereafter.)*

First Aid**	
Defensive Driving**	
Abuse-Prevention**	
Passenger Assistance**	
Ambulatory Passenger Assistance	

By signing this section, you acknowledge that you have completed all the necessary training mentioned above and are able to provide a copy of your certificate(s) upon request.

Driver Signature:	Date:
Driver Name (Please Print):	
Supervisor Signature:	Date:
Supervisor Name (Please Print):	



CLAIM REQUIREMENTS FOR ASSISTED TRANSPORTATION ONLY

As of 1-1-21 the Driver License number of the person who transports the member will be required on the 837P claim. On Codes T2003, T2005 and A0130 the Loop 2400 under SV101-7, the description field must include the driver's license number, or the claim will reject/deny. The number must be a valid driver license number with no spaces or dashes.

To gather diversity information about our provider network we ask that you complete the information below.

Please indicate the percentage of your Drivers who identify as one of following groups:

Ethnicity/Gender	Drivers	Ethnicity/Gender	Drivers
1. Asian		6. Native American or Alaskan Native	
I. Male	%	I. Male	%
II. Female	%	II. Female	%
III. Other: <i>please specify</i>	%	III. Other: <i>please specify</i>	%
2. Black or African American		7. White	
I. Male	%	I. Male	%
II. Female	%	II. Female	%
III. Other: <i>please specify</i>	%	III. Other: <i>please specify</i>	%
3. Hawaiian or Pacific Islander		8. Multiracial or Biracial	
I. Male	%	I. Male	%
II. Female	%	II. Female	%
III. Other: <i>please specify</i>	%	III. Other: <i>please specify</i>	%
4. Hispanic or Latinx		9. A race/ethnicity not listed here. Please Specify below	
I. Male	%	I. Male	%
II. Female	%	II. Female	%
III. Other: <i>please specify</i>	%	III. Other: <i>please specify</i>	%
5. Middle Eastern			
I. Male	%		
II. Female	%		
III. Other: <i>please specify</i>	%		
		Total number of Drivers: _____	

I certify that the information provided on this form is true and correct. I will notify South Country Health Alliance Provider Network Department of any additions or changes to the information provided within 30 days of the addition or change.

Contract signor name (print):	Title:
Contract signor signature:	Date:
Telephone number:	Email address:

If you have any questions regarding this form, please contact us at providerinfo@mnscha.org. As a reminder, please let us know of any changes your business may have within 30 days of the change.