505 E. Huntland Drive
Suite 270
Austin, TX 78752

Office (877) 564-9838
Fax: (877) 931-4757
Modivcare.com

Dear Individual Transportation Participant,

On behalf of Modivcare, I welcome you as a potential Individual Transportation Participant (ITP) and hope you will find providing transportation services rewarding.

Enclosed are the following enrollment items needed to complete the application process:

- ITP Enrollment Packet
- Disclosure and Authorization Form **(Non-Family Members Only)**
- Acknowledgment and Authorization of Background Check **(Non-Family Members Only)**

Please read **ALL** of the enclosed information carefully and return original signed copies to the address provided in the enrollment packet.

For any application with a relationship status of “Non-Family Member”, Modivcare will be required to conduct a criminal background check and motor vehicle driving record check on the participant’s behalf.

Best Regards,

Gerritt Gehan
Sr. Director, Client Services
Modivcare

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Individual Transportation Participant (ITP) Enrollment Checklist

Use this checklist to make sure all the items needed to sign up to be an ITP are completedand submitted. No trips will be authorized until all documents have been approved.

For help filling out these forms, call Modivcare Contact Center at **866-529-2117 or 866-528-0441.**

- ☐ Original completed ITP Information Page
  (*Please fill out everything, and mark N/A where if a question does not apply.)*
- ☐ Original completed Client/ITP Information Page
- ☐ Original completed Terms and Conditions of Participation signature
- ☐ A copy of your current and valid Texas Driver's License
- ☐ A copy of your current and valid Texas auto insurance card (declarations page or insurance card showing it has minimal requirement by law)
- ☐ A copy of your Social Security card
- ☐ A copy of vehicle registration

Important: The name listed on your driver's license and Social Security card must be the same.

All ITP Packets request must be mailed with original signatures; all other documents may be faxed to 1-877-931-4757 and/or email to Tx.credentialing@Modivcare.com.

All forms must be mailed to Modivcare

ATTN: Modivcare

505 E. Huntland Drive Suite 270

Austin, TX 78752

Note: *Please retain a copy for your records.*

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ITP Information Page

The purpose of the form is to obtain data to sign up to be an ITP. You must fill out this entireform and sign it. Please use blue or black ink. Original signature only; copies or stamped signature will not be accepted.

ITP Status: Self/Other:	**Telephone Number:(if we need to contact you)**
☐ Self ☐ Other	( )

Must match Driver's License **Last Name :**	**First Name:**	**Middle Initial:**

Social Security Number:(*Please attach copy of card)*	**Date of Birth:**

Driver's License Number: ***(Please attach a copy of driver's license).***	**License Issue Date:** *MM/DD/YYYY*	**License Expiration Date:** *MM/DD/YYYY*

Physical Address: ***This is where you live. (You must give a street address. PO boxes will not be accepted.) Number, Street, City, State, and Zip Code***

Mailing address: ***Number, Street, City, State, and Zip Code.***

Gas Reimbursement App:	**Email Address:**
☐ Opt In ☐ Opt Out	

Important: the name on your driver's license, social security card must be the same.

Vehicle & Insurance Information

Vehicle Identification Number (VIN): ***Please provide VIN of vehicle used to transport.***	**License Tag:**

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Client/ITP Information Page

If you are driving yourself or family members only, fill out **Section 1, leave Section 2 blank**.
If you are driving a person other than yourself or a family member, fill out **Section 1 and Section 2**.
*Please list all clients for which driver will be requesting reimbursement

Section 1

Client Name: *(the person you will be driving)*	**Medicaid ID #:**	**Client DOB:** ***MM/DD/YYYY***	**Relationship to ITP:**
			☐ Family Member ☐ Non-Family Member ☐ Self

Section 2 (*Facts about the ITP*)

Are you currently charged with or have you even been convicted of a crime (excluding Class C misdemeanor traffic citations)?

☐ **YES** ☐ **NO**

"Convicted" means that:

i) A judgement of conviction has been entered against an individual by a Federal, State, or local court, regardless of whether:
  (1) There is a post-trial motion or an appeal pending; or
  (2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;
ii) A Federal, State, or local court has made a finding of guilt against an individual;
iii) A Federal, State, or local court has accepted a plea of guilty or nolocontendere by an individual, or
iv) An individual has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgement of conviction has been withheld.

*If **Yes**, fully explain the details including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of (attach additional sheets if necessary).*

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Terms and Condition of Participation

1. ***Before an ITP drives a client, the client must get approval for the ride from Modivcare. The client must call 1-866-529-2117 or 1-866-528-0441 to get this approval prior to the trip otherwise the ITP will not get paid. All clients must be listed on the Client/ITP Page.***

2. ***The client must have the doctor, office manager, nurse, PA etc sign the ITP Service Record (Claim Form) and the ITP must sign the ITP Service Record (Claim Form).***

3. ***The mileage reimbursement (payment) amount is based on a mileage calculation computed by Modivcare using a nationally recognized system of the shortest distance of the trip and not on the number of clients who are given a ride. The ITP will be paid based on the determined mileage at the vehicle mile rate set by the Texas Legislature for state employees that is in effect at the time of the ride.***

4. ***All payments to an ITP will be reported to the Internal Revenue Service (IRS).***

5. ***The ITP must maintain a current and valid Texas driver's license, Texas vehicle insurance, Texas vehicle inspection during each ride.***

6. ***The claim form must be submitted within 95 days from the date of the ride.***

Attestation:

I attest that I have read the terms and conditions of participation as an Individual Transportation Participant (ITP) and that the information provided in this application is true and correct. I understand that I must comply with the terms and conditions of participation and maintain documentation to support any mileage reimbursement claim and that HHSC or Modivcare reserves the right to request and validate documentation being relied upon to support mileage reimbursement claims.

Signature of Individual Transportation Participant (ITP)

Date

STATE

Mileage Reimbursement

Just Got a Whole Lot Easier

Need to schedule transportation for a Medicaid covered service? Consider mileage reimbursement!

With the new mileage reimbursement app on your smart phone, you can now view and submit claims electronically. Soon, you will be able to submit both your transportation requests and mileage reimbursement at the same time.

For your convenience, your Reimbursement Funds are added directly to a MasterCard debit card.

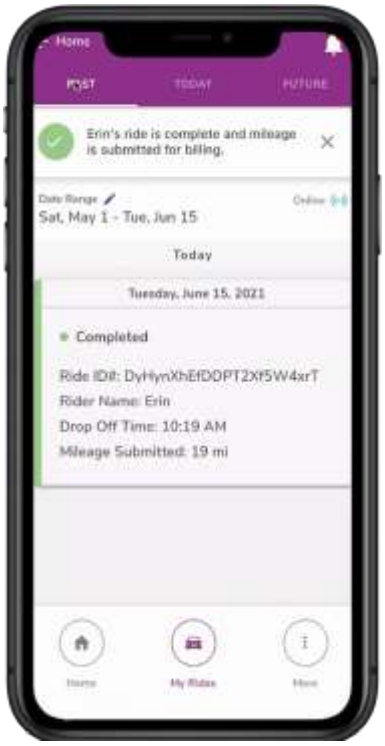
The app eliminates:

- Paperwork and bringing trip log sheets to
- Calling to obtain trip numbers and any errors
- Cost of faxing and mailing reimbursement requests

How to get started:

Ask about the mileage reimbursement app the next time you call reservations to schedule transportation for a Medicaid covered service. Be sure to have your smart phone or tablet and a valid email address with you.

Existing Members can contact the Credentialing Department directly at: 1(877) 564-9838 or send an email to: tx.credentialing@modivcare.com. *Please type 'Activation of Gas Reimbursement APP' in the subject line.*



Reservation contacts:

United Healthcare Tx

1(866) 529-2117	1(866) 528-0441	1(866) 427-6607
(Star Kids)	(Star, Star Plus, & Chip)	(MMP)

ITP Gas Reimbursement (Claim Form Example)

ID can be found on Medicaid card

Client Name:	Client Telephone:	Client Medicaid:
John Doe	(123) 456-789	000111222
ITP Name (Must match Driver's License)	**ITP Telephone:**	**ITP MTI Number:**
James Jones Smith	(987) 654-321	333444555

Driver's name assigned to trips

Driver's license number

Trip #1

From:	To:	Miles:	Amount:
1234 Main St.	8910 Broadway	10	20
From:	**To:**	**Miles:**	**Amount:**
8910 Broadway	1234 Main St.	10	20
Authorization Number:	**Appointment Date:**	**Total Miles:**	**Total Amount:**
12345	02/28/2023	20	40
Health Care Provider NPI:	**Health Care Provider Telephone:**	**Health Care Provider Name:**	
9876543211	(555)123-456	General Hospital	

This number is provided at the time of reservation with Modivcare.

Number can be collected from Healthcare Provider

I c vas seen for a Medicaid/ CS are service.	Signature & Title of Health-care Provider:	Date Signed:
	Dr. Jane Johnson	03/01/2023

Trip #2

From:	To:	Miles:	Amount:
From:	**To:**	**Miles:**	**Amount:**
Authorization Number:	**Appointment Date:**	**Total Miles:**	**Total Amount:**
Health Care Provider NPI:	**Health Care Provider Telephone:**	**Health Care Provider Name:**	
	( )		

I certify that this patient was seen for a Medicaid/ CSHCN covered health-care service.	Signature & Title of Health-care Provider:	Date Signed:

ITP Drivers: *Please note that the allowable mileage that may be claimed for reimbursement is preprinted on the form.*

AFFIDAVIT: This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim is from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws. I hereby certify that this claim contains no willful misrepresentation or falsification and that the information I have given is true and correct to the best of my knowledge and belief. **I attest that I have complied with all of the provisions of the Individual Transportation Participant Agreement when providing the transportation services for which I am seeking reimbursement.**

James Jones Smith

Signature of Individual Transportation Participant (ITP)

03.01.2023

Date

Claim form must be mailed to Modivcare

ATTN: Claims 798 Park Ave NW 4th Floor Norton, VA 24273

Emailed to: support.claims@modivcare.com

Faxed to: 866-528-0462

Note: *Please retain a copy for your records*

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ITP Gas Reimbursement (Claim Form)

Client Name:	Client Telephone:	Client Medicaid:
	( )	
ITP Name (Must match Driver's License)	**ITP Telephone:**	**ITP MTI Number:**
	( )	

Trip #1

From:	To:	Miles:	Amount:
From:	**To:**	**Miles:**	**Amount:**
Authorization Number:	**Appointment Date:**	**Total Miles:**	**Total Amount:**
Health Care Provider NPI:	**Health Care Provider Telephone:**	**Health Care Provider Name:**	
	( )		
I certify that this patient was seen for a Medicaid/ CSHCN covered health-care service.	**Signature & Title of Health-care Provider:**	**Date Signed:**	

Trip #2

From:	To:	Miles:	Amount:
From:	**To:**	**Miles:**	**Amount:**
Authorization Number:	**Appointment Date:**	**Total Miles:**	**Total Amount:**
Health Care Provider NPI:	**Health Care Provider Telephone:**	**Health Care Provider Name:**	
	( )		
I certify that this patient was seen for a Medicaid/ CSHCN covered health-care service.	**Signature & Title of Health-care Provider:**	**Date Signed:**	

ITP Drivers: ***Please note that the allowable mileage that may be claimed for reimbursement is preprinted on the form.***

AFFIDAVIT: This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim is from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws. I hereby certify that this claim contains no willful misrepresentation or falsification and that the information I have given is true and correct to the best of my knowledge and belief. **I attest that I have complied with all of the provisions of the Individual Transportation Participant Agreement when providing the transportation services for which I am seeking reimbursement.**

Signature of Individual Transportation Participant (ITP)

Date

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